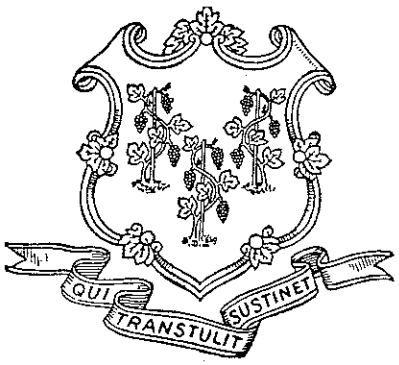
REGULATION AND OVERSIGHT OF MANAGED CARE

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1996

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Regulation and Oversight of Managed Care

DECEMBER 1996

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Introduction

Regulation and Oversight of Managed Care

The Legislative Program Review and Investigations Committee authorized a study in February 1996 to determine whether the regulatory structure in place is adequate to oversee the managed health care industry in Connecticut. The focus of the study has been to evaluate the balance that exists between regulating the industry for quality of care and patient protection with the health plans' ability to implement cost containment measures.

Specifically, the scope called for an examination of what oversight and controls the regulatory structure provides in each of the following areas:

- consumer protection efforts;
- utilization review of health care services;
- medical protocols used for the utilization of health services;
- licensing process of managed care plans;
- provider protection issues; as well as
- a review of other regulatory models.

In conducting the study, staff visited sites at six health maintenance organizations (HMOs), interviewed staff from state agencies, employers, labor groups, hospitals, insurers, and trade associations representing various groups involved in managed care. In addition, committee staff held five different provider focus groups around the state and held four public hearings in various locations.

Staff also reviewed the managed care literature and examined files at the Department of Insurance (DOI) and the Office of Health Care Access (OHCA). In addition, staff analyzed material requested from the HMOs, including protocols and utilization data. Staff examined and compiled financial data from annual financial reports filed with the Connecticut Insurance Department and from A.M. Best's Annual Reports on HMOs.

The committee found consumers need greater information to make health care decisions and increased consumer protections when they have a problem with their health plan. To meet those goals, the report makes recommendations to improve utilization review, consumer complaints, protocol development and use, and provider contracting issues.

At both the federal and state levels, there has been a public policy determination to use HMOs as a way of containing medical care costs. It is

logical then that government not place burdensome regulatory requirements that prevent HMOs from meeting that goal. The study concludes that dramatic change in managed care is premature when it appears to be improving affordability of health care overall, increasing coverage statistics for Connecticut residents, and receiving generally good satisfaction ratings from the public.

The report also cautions that dramatically increasing regulation might prompt more employers to self-fund their health plans, thereby legitimately escaping state regulation through the federal Employee Retirement Income Security Act (ERISA) exemption. Further, significantly expanding regulation might put the recent improvement the state has experienced in expanding coverage for small employers at risk.

The report contains six chapters. Chapter I provides a background to health care in Connecticut, including costs and coverage issues. Chapter II profiles Connecticut HMOs using several financial and utilization measures and compares them to other states. Chapter III examines the current regulatory structure in Connecticut. Chapter IV makes findings and recommendations related to consumer protection efforts. Chapter V examines benefits, utilization review, and protocols. Finally, Chapter VI focuses on provider issues including selection, contracting, and termination.

Agency Response

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to review the opportunity to comment on recommendations prior to publication of the committee's final report. The response from the Department of Insurance is contained in Appendix A.

Key Points

CHAPTER I : BACKGROUND ON HEALTH CARE COVERAGE AND COSTS

- Nationally, growth in enrollment in managed care plans, especially HMOs, has been dramatic.
- Connecticut's move to HMOs has mirrored the nation's, and currently about one-third of the state's population is enrolled in an HMO.
- Connecticut's percentage of uninsured remains one of the lowest in the nation.
- Connecticut had 85,000 more residents with private group health insurance in 1995 than it did in 1994, reversing a previous trend and bucking a national phenomenon of a growing uninsured population.
- Connecticut's aggregate premium costs continued to increase from 1980 through 1995.
- HMO enrollment covers about one-third of Connecticut's population, yet HMO premiums account for about 25 percent of health care insurance premiums.
- The gap between the annual increases in the Consumer Price Index (CPI) for all items and the growth in the medical portion has been narrowing. The annual increases for 1996, as of October, were 3 percent for total CPI and 3.2 percent for the medical portion, the lowest growth in the 10 years examined.
- Per-employee costs are less in HMO coverage than with indemnity plans in Connecticut, and, according to one employer survey, both cost less in 1995 than they did in 1994.

Chapter I

Background

Over the past 10 years employers have increasingly turned to managed care as a brake on their rapidly spiraling health care costs. The failure of any national health care reform in 1994 accelerated their movement to managed care plans. Government, too, has now begun enrolling its own employees, as well as Medicaid and Medicare clients, to slow rising costs of health care benefits.

Definitions

There is no single definition of the term "managed care." Managed care is on a continuum, with a number of plan types offering an array of features that vary in their ability to balance access to care, cost, quality control, benefit design, and flexibility. Some of the common types of managed care plans are:

- **health maintenance organizations** (HMOs) which provide a pre-arranged set of basic and supplemental medical services to an enrolled group, and patients are restricted to providers in the network;

- **preferred provider organizations** (PPOs) refers to a system where a third party (like an insurer or employer) negotiates discounted rates for services for those enrollees in that plan, but insured patients can see other providers at a higher cost; and

- **point-of-service plans** (POS) whereby members receive care from participating providers, but have the option of getting care outside the network, usually at higher cost to the member through deductibles and co-pays.

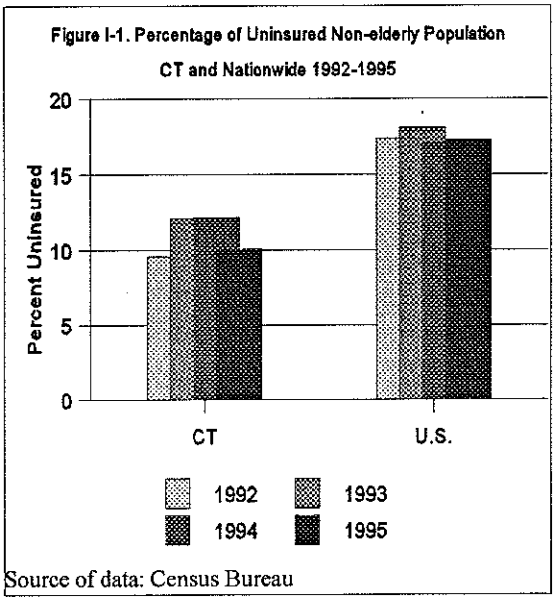
This list is certainly not exhaustive of the types of managed care organizations. They continue to evolve, with components from one type of plan appearing in others and new features continually being developed. A glossary of managed care terms appears in Appendix F.

Trends in Coverage

Managed care is relatively new, and at this point it is difficult to gauge what impact it is having on the availability of health care coverage for Connecticut residents. This chapter compares trends in health care coverage in

Connecticut with national trends between 1992 and 1995. The results are shown in Figure I-1. In addition to comparing Connecticut's uninsured population with the nation's, the committee also contrasts state percentages between 1992 and 1995 with those in other states and displays the results in Table I-1.

Analysis. The committee reaches several conclusions from the data on coverage. Connecticut's uninsured population -- 10.1 percent in 1995 -- continues to be a smaller percentage than the nationwide average of about 17.5 percent. The most recent Connecticut data show a reversal from the 1993 and 1994 trend of growing uninsured. In 1995, the proportion of uninsured in the state was almost as low as its 1992 level.



Source of data: Census Bureau

These data buck the national phenomenon of the growing uninsured, and appear to have several causes. The first reason is due to an increasing Medicaid population. In 1994, there were 208,000 persons covered under Medicaid; in 1995 268,000 persons under age 65 were in the program.

Secondly, there has been a substantial increase in the number of persons covered by employer group health insurance between 1994 and 1995. The Current Population Survey conducted in March 1996 by the U.S. Bureau of the Census reports that the 1995 data show an added 85,000 persons under age 65 were covered by group health insurance in Connecticut. A one-year drop may not indicate a downward trend in the uninsured, and data on 1996 coverage levels will not be available for a few months, but the program review committee believes there may be several reasons to be encouraged by these data.

Group health insurance coverage is closely connected with the job market -- as fewer persons become unemployed, the less likely they are to be uninsured.[1] Thus, as Connecticut has experienced a growth in jobs -- 1,528,800 jobs in March 1994 to 1,565,100 jobs in March 1995, and a corresponding drop in the unemployment rate from 5.7 to 5.4 for the same period -- a growth in health coverage has also occurred. Secondly, the state legislature passed legislation, P.A. 90-134

[1] Unemployment is one of the most common reasons for lack of health insurance. A recent study by the American Hospital Association cites that only about 18 percent of persons eligible for extension of health care benefits under COBRA are actually covered. (COBRA is federal legislation that allows persons to continue health benefits for a period following employment if the individual pays the group rate premiums, but among the reasons for not obtaining coverage is many unemployed persons cannot afford even the group rates.)

(revised in subsequent legislative sessions), that made it easier for smaller employers to obtain group health coverage. By statute, health insurers (including HMOs operating in relevant areas) must now guarantee coverage to employers with three or more persons; insurers are prohibited from terminating an employer's coverage because of health claims, and insurance portability was greatly improved.

In addition, associations like the Connecticut Chambers of Commerce and the Connecticut Business and Industry Association (CBIA) have put together purchasing alliances of their members so that more choices of health insurance, including managed care products, are available to small employers at affordable prices. The chamber alliance also offers coverage to employers with only one member. CBIA insurance officials indicate that about 10 percent of their insured employers did not have health insurance before. Employers also state that managed care products have introduced price competition to group health insurance, making it more affordable for employers to purchase health coverage for their employees.

As shown in Table I-1, Connecticut has achieved the second lowest percentage of uninsured population among the 10 states compared. Only Minnesota, with an average rate of 10.5 over the past four years, was lower. Texas, Florida, and California, on the other hand, all had more than 20 percent of their populations uninsured.

Table I-1. Percentage of Uninsured By State: 1992-1995

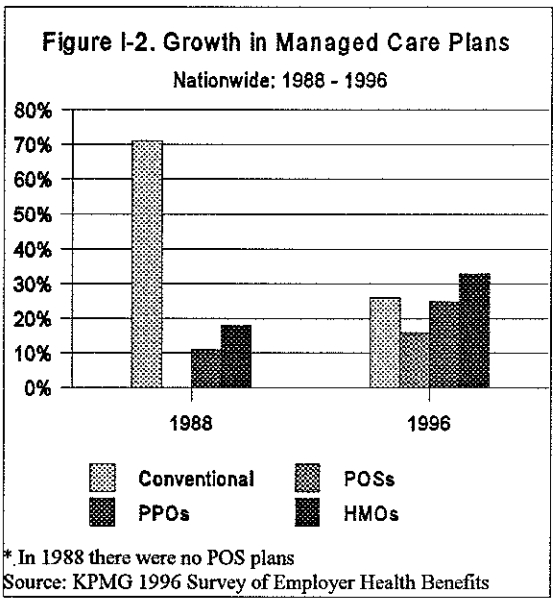
	1992	1993	1994	1995	4-year average
CT	9.6	12.1	12.2	10.1	11
MA	12.4	14.1	14.2	12.5	13.3
NJ	15.3	16.2	14.7	16.2	15.6
OR	15	17.2	14.8	13.9	15.2
CA	22.0	22.7	23.5	22.6	22.7
FL	24.2	24.1	20.5	21.7	22.6
MN	10	12.7	10.6	9.0	10.5
TX	25.7	25.1	26.5	27.0	26
MD	14.0	17.2	14.1	17.2	15.6
NY	16.1	16.5	18.2	17.2	17

Source of data: U.S. Bureau of the Census

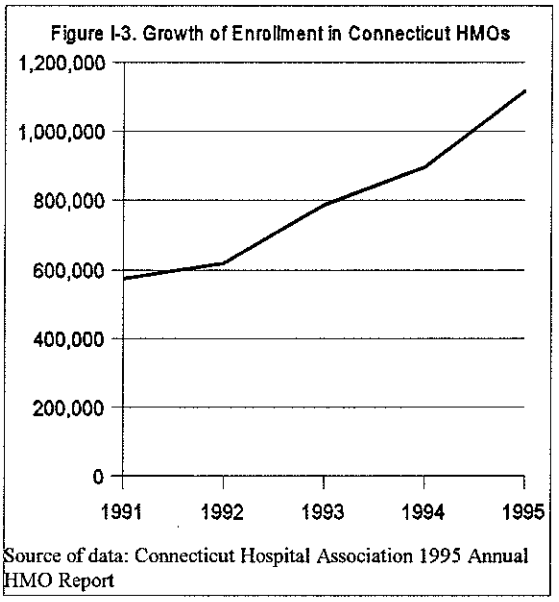
Trends in Types of Coverage

More and more persons nationwide are covered by insurance plans that include some type of managed care. Figure I-2 shows the growth of managed care plans nationally. Since 1988, the health care market has shifted from predominately conventional plans to a market where managed care plans now dominate. In fact, the market share of HMOs alone now surpasses conventional plans.

Connecticut's experience with managed care enrollment is similar to the nation's. In Connecticut, approximately one million people (about one-third of the population) are now enrolled in HMOs. Figure I-3 plots the phenomenal growth in Connecticut HMO coverage between 1991 and 1995.



* In 1988 there were no POS plans
Source: KPMG 1996 Survey of Employer Health Benefits



Source of data: Connecticut Hospital Association 1995 Annual HMO Report

Trends in Costs of Health Care

Connecticut's total health care costs are still increasing. Table I-2 lists Connecticut's aggregate health care costs for five-year intervals from 1980 through 1990, and for 1992 and 1993, the two most recent years with available data. These data include all health care expenses from the provider source (hospitals, laboratories, pharmacies, doctors), and thus does not provide information on whether the purchaser had insurance or not.

The table also contrasts Connecticut's data with several other states being used in this study for comparative purposes. The right column of the table indicates the annual increases averaged over the 13-year period, and, as indicated, Connecticut experienced the fourth-highest growth rate of the states compared. Total health care costs in the state increased by 11 percent a year between 1980 and 1993, and overall almost quadrupled during that 13-year period.

Table I-2. Total Health Care Expenditures : State Comparison (000,000)

State	1980	1985	1990	1992	1993	Average Annual % increase 1980-1993
CT	$3,151	$5,588	$9,976	$11,572	$12,216	11%
MA	$6,651	$11,261	$19,170	$21,969	$23,421	10.2%
NJ	$6,459	$11,638	$19,951	$23,978	$25,741	11.2%
OR	$2,356	$3,844	$6,137	$7,349	$7,999	9.9%
CA	$26,524	$46,267	$74,116	$88,215	$94,178	10.2%
FLA	$9,795	$19,897	$35,127	$41.958	$44,811	12.4%
MN	$4,241	$7,289	$11,511	$13,328	$14,194	9.7%
TX	$12,689	$23,035	$37,268	$46,092	$49,816	11.1%

Source of data: Health Care Financing Administration

When measured on a per-capita basis, as shown Table I-3, the percent increase in health care expenses in Connecticut were similar. As Table I-3 indicates, Connecticut's annual average per capita growth rate in health care from 1980 to 1993 was similar to aggregate cost increases -- about 11 percent -- but Connecticut ranked second highest of the states compared.

Table I-3. Per-Capita Health Care Costs by State 1980-1993

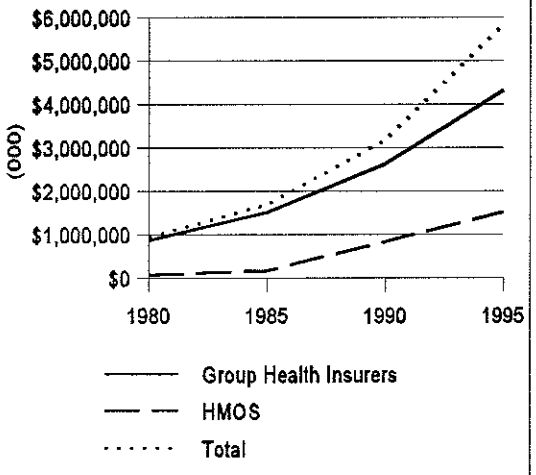
State	1980	1993	Total % Increase 1980-1993	Average Annual % Increase (1980-1993)
CT	$1,012	$3,726	268%	11%
MA	$1,157	$3,891	236%	9.3%
NJ	$876	$3,275	273%	11.2%
OR	$892	$2,635	195%	8.3%
CA	$1,114	$3,016	171%	7.8%
FL	$995	$3,264	228%	9.2%
MN	$1,038	$3,137	202%	8.6%
TX	$884.	$2,764	213%	9%

Source of data: Analysis of Health Care Financing Administration Data

Health insurance premiums. As discussed, these expenditure figures are measured using the costs of *all* health care (including nursing home care, prescriptions, dental care, hospitals and doctors) being purchased in the state regardless of who purchases it. In addition to these expense data, trend information on aggregate health care premiums in Connecticut 1980 through 1995 are graphed in 5-year intervals in Figure I-4.

As the graph shows, aggregate premiums for both regular health insurers and HMOs continue to rise. Also, regular health insurers still capture more of the private insurance premium market than do HMOs in Connecticut -- more than $4 billion to regular health insurers compared to $1.5 billion to HMOs. However, it is interesting to note that, while HMO enrollment in 1995 covers about one-third of Connecticut's population, as mentioned above, HMO premiums account for only about 25 percent of all health care insurance payments.

Figure I-4. Health Care Premiums in CT
1980-1995

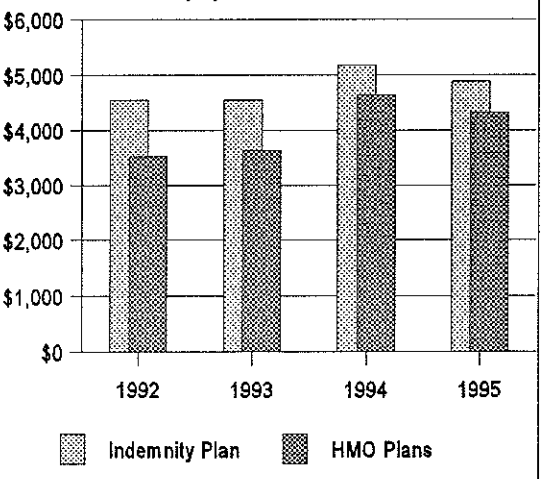


Source of data: DOI Annual Reports

It is impossible to obtain an average premium cost per-employee from the total premium dollars spent, because no data exist on how many people are actually covered with the premium dollars collected by regular health insurers. As a substitute for a per-employee costs for health care premiums, program review used data collected by Foster Higgins, a national health care consulting firm that annually surveys more than 2,500 employers on their health care benefits and costs.

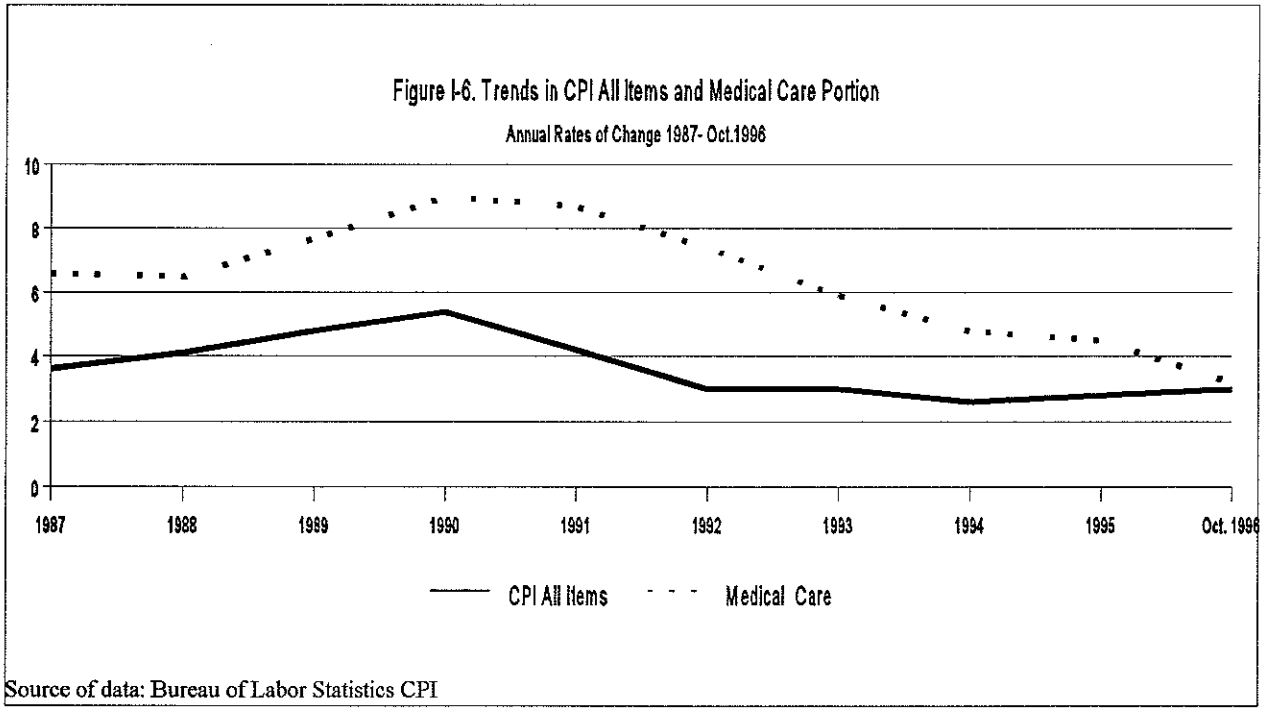
Figure I-5 shows the per-employee health costs for those employers surveyed in Connecticut from 1992 through 1995. As the graph shows, per-employee benefit costs are less with HMO coverage than in traditional indemnity plans. Also worthy of note is that 1995 per-employee costs in both types of plans are lower than 1994 costs.

Figure I-5. Costs of Health Benefits in CT.
Per-employee Costs: 1992- 1995



Source of data: Foster Higgins Annual Survey

Because 1993 is the last year with available aggregate health care costs, it is difficult to show the impact, if any, managed care has had on costs. This is especially true in Connecticut, where significant expansion of managed care has been recent. However, one national measure of costs that is slowing considerably is the medical portion of the consumer price index (CPI). Figure I-6 below shows that, while still somewhat higher than the CPI overall, the 1996 percentage increase in the medical care portion (up to October 1996) is the lowest it has been in ten years charted. While some of this decline in growth rate may be due to general economic conditions, it is safe to assume that managed care has played some role.



Source of data: Bureau of Labor Statistics CPI

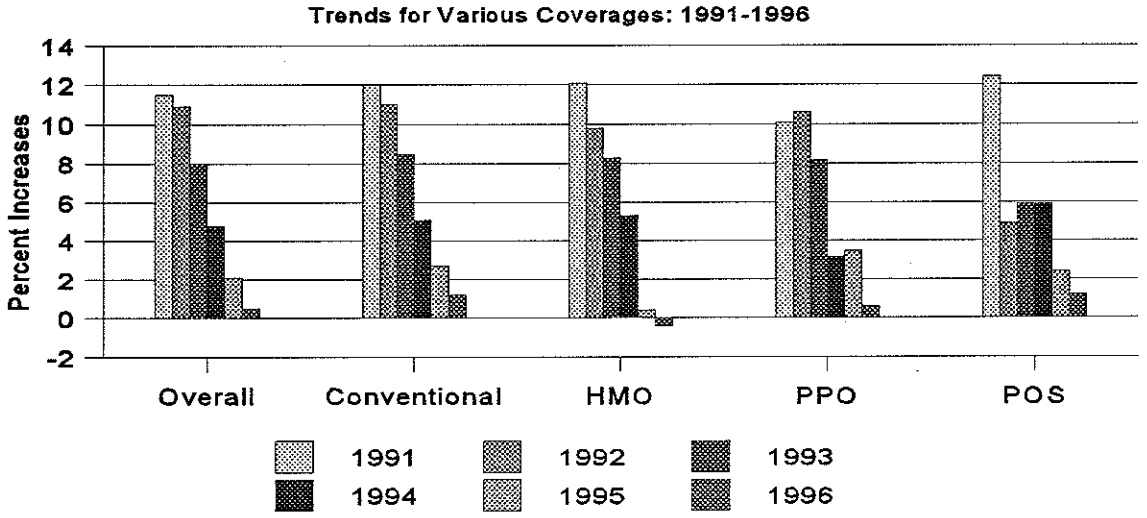
A study conducted by the General Accounting Office (GAO), and released in 1993, stated that savings from managed care were not obvious at that point. "Although many employers believe that they are saving money from network-based managed care, the evidence has been inconclusive about the extent to which such plans hold down employers' costs."[2] It further stated that none of the recent surveys [prior to 1993] of employers' premiums adjust for differences in enrollee characteristics or benefits covered in network-based managed care and indemnity plans.

However, more recent surveys appear to show employer-sponsored health care costs increasing at much lower rates than two or three years ago, especially for HMO coverage. Figure

[2]Managed Health Care: Effect on Employers' Cost Difficult To Measure, General Accounting Office, October 1993.

I-7 shows the rates of increases for health plan premiums, as cited in an annual report issued by KPMG Peat Marwick, an international consulting company. The premium increases are based on an annual survey KPMG conducts of more than 1,000 large employers nationwide. As the figure shows, not only has the trend overall come down dramatically -- from almost 12 percent average increases in 1991 to about 1 percent overall growth in premiums in 1996 -- but in fact the 1996 rates for HMOs actually dropped slightly. Of course, as the GAO study points out, these surveys do not measure the impact that differences in coverages, or higher co-pays on the part of employees, might contribute to lower employer premiums.

Figure I-7. Percent Changes in Employer Health Costs

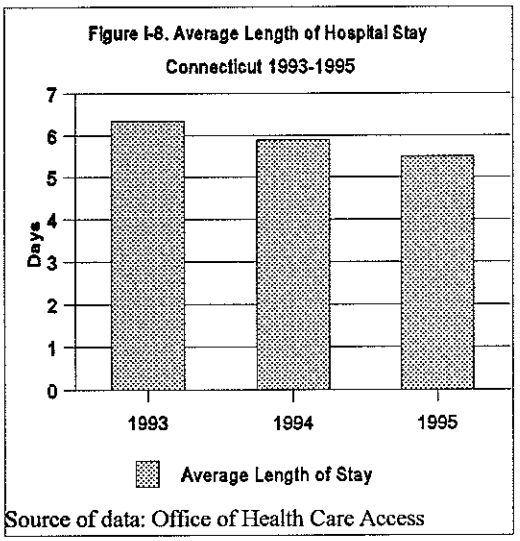


Source of data: KPMG Survey of Employers 1995

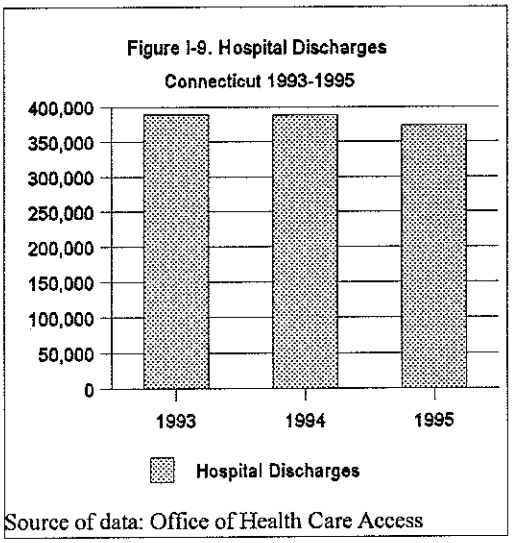
Trends in utilization. The decline in utilization is also obvious. A study conducted by the Congressional Budget Office[3], using data from the 1992 National Health Interview Survey, showed that health maintenance organizations reduce use of health care services by an average of about eight percent. The study found that there was great variation in the reduction in services depending on the HMO model, with group/staff model HMOs reducing services by 21 percent, while other models that contract with groups of physicians reduced use by 3.6 percent. The study concludes that it would be impossible, due to geographical obstacles among others, to have everyone enroll in group model HMOs, but if all insured persons who were in totally unmanaged care had been enrolled in effective utilization review programs and those in effective HMOs did not change, insured services would have been lower by 1.3 percent in 1990, and total national health expenditures would have been 0.9 percent less.

[3] "The Effects of Managed Care and Managed Competition", Congessional Budget Office, Washington D.C., February, 1995, p. 12.

Trends in utilization in Connecticut. One of the aspects of managed care is to control the use of medical treatments and substitute expensive and/or invasive procedures with less costly measures and in less expensive settings. Again, it is not possible to indicate the extent to which managed care alone is responsible, but health care statistics show that there has been some reduction in certain types of health care utilization in Connecticut.



Source of data: Office of Health Care Access



Source of data: Office of Health Care Access

For example, hospital admissions and hospital stays are declining fairly rapidly, as depicted by the figures above. Figure I-8 shows that the average length of stay in hospital has gone from 6.34 days in 1993 to 5.5 days in 1995, a decrease of about 15 percent in just two years. Figure I-9 illustrates that the number of hospital discharges is also shrinking, though not as dramatically -- in 1993 there were 389,243 persons discharged from Connecticut hospitals and in 1995 373,416 discharges occurred, a decrease of 4 percent.

The decline in inpatient care is basically the result of controlling utilization, but it is also due to HMOs and other insurers negotiating deep discounts with hospitals, creating economic incentives to treat patients in other than in-patient settings, and not to keep them as long when they are admitted. Of course, technological advances have also helped to reduce the necessity of in-hospital stays, but exploded the number of outpatient procedures performed. Nationally, only 16 percent of surgeries were performed on an outpatient basis in 1980; by 1993, 55 percent of them were. In Connecticut, the experience has been similar. In 1985, 71,213 "same-day" medical procedures were performed; by 1995 there were 273,771 such procedures, almost 4 times as many in 10 years.

Key Points

CHAPTER II : PROFILE OF HMOS

- The managed care industry is growing rapidly in Connecticut. Currently, there are 16 fully licensed HMOs -- three of them were licensed in 1995 and two in 1996.
- Connecticut's HMO premiums totalled $1.5 billion in 1995.
- Seven of 11 Connecticut HMOs that were operational in both 1994 and 1995 had lower monthly fees in 1995 than they had the previous year.
- Typically, most Connecticut HMOs expend more than 80 percent of premium dollars on health care.
- Of the states compared in this study, most have both for-profit and non-profit HMOs.
- Some variation in utilization and financial measures exists between for-profit and non-profit HMOs, but differences vary among states and measures compared.

Chapter II

Profile of Connecticut HMOs

Connecticut's managed care industry is changing so rapidly it is difficult to identify the industry's participants at any given time. Connecticut currently has 16 fully licensed HMOs. Two of these -- Medspan and NYLCare -- were licensed in May 1996, while Yale Preferred was approved in December 1995. Two other HMOs, Healthsource, and Wellcare, became licensed during 1995 but are just beginning to become operational. Blue Cross/Blue Shield has now consolidated its three preceding HMOs -- Community Health Care Plan, Constitution Health Care, and Enterprise -- into one line of HMO business under BlueCare. Aetna and U.S Healthcare finalized a well-publicized but controversial merger of their HMO business in July 1996. Revenues for all Connecticut HMOs for 1995 totaled slightly more than $1.5 billion.

This chapter provides a brief profile of active HMOs in Connecticut. Table II-1 offers summary statistics of Connecticut's HMOs that had active enrollment during 1995. The profile begins in 1991 (or date of licensure, if after 1991). Most of the profile concentrates on financial statistics, but the final piece of data for each HMO listed is a utilization measure. The statistics were compiled by A.M. Best Company, which collects information on insurance companies and rates their financial condition, and are based on data from each HMO's annual financial reports filed with the insurance department.

The HMO companies are listed across the top of the table, (along with their tax status) and the statistics are down the columns under each company's name. The first row in each column lists each HMO's year-end enrollment. The second row contains the average per-member per-month fee for all the plans the HMO offers (which is based on total premiums divided by total members divided by 12). Worthy of note is that 1995 monthly rates or fees dropped from their 1994 levels for seven of the HMOs profiled.

The third row lists the percentage of premiums spent on health care, the "medical loss ratio." As the table shows, for most HMOs this ratio is typically above 80 percent. Exceptions are the medical loss ratios for: Prudential from 1991 through 1993; U.S. Healthcare for 1993 and 1994; Physicians Health Services for 1994 and 1995; Suburban for 1991,1992, and 1993; and Cigna and MD Health for 1995.

The percentage of premiums spent on administration is listed on the fourth row. In general, the percentage of premiums devoted to administration

Table II-1. Profile of Connecticut HMOs

Company	Aetna	Blue Care	Cigna	CHCP	Connecticare	Constitution	Kaiser	MD Health	Oxford	PHS	Prudential	Suburban	US Health
tax status	non-profit	non-profit	for-profit	non-profit	non-profit	non-profit	non-profit	for-profit	for-profit	for-profit	for-profit	for-profit	for-profit
1991 Enrollment	20,550		40,573	48,159	106,600	97,542	46,746	61,236		119,889	2,401	1,937	13,602
pmpm fee*	$128.36		$124.00	$158.22	$124.30	$138.66	$114.68	$119.87		$146.41	$108.58	$141.51	$135.60
% health care	82.3		95.7	87.5	88.2	85.4	80.9	90		86	55.6	73.8	85.4
% admin.	15.6		11.2	11.7	10.5	13.2	17.6	10		10.3	23.4	25.2	16.6
% gross profit	3.4		-1.9	1.6	2.4	2.4	4.9	2.4		5	26.9	3.9	1.1
Physician visits/1000	5,119		3,729	3,717	4,596	5,633	2,845	3,935		4,239	3,039	3,902	4,440
1992 Enrollment	27,825		20,662	46,912	111,607	96,872	48,445	72,864		122,131	2,966	2,248	22,579
pmpm fee	$121.42		$127.11	$167.42	$140.10	$150.77	$128.50	$124.16		$159.28	$121.29	$148.47	$136.88
% health care	88.1		95	89.6	88.5	87	83.1	89.6		84.5	60.4	78.1	86.7
% admin.	13.7		12.1	12.4	10.7	12.2	14.9	10.1		11.4	20.4	23.4	14.4
% gross profit	-1.1		3.4	-1.3	1.7	1.8	6.5	1.81		5.4	22.4	1.9	1.1
Physician visits/1000	5,492		3,229	N/A	4,813	2,719	3,037	4,579		2,886	3,495	5,525	4,157
1993 Enrollment	45,341	78,343	9,578	45,349	99,165	98,089	46,259	114,800		139,542	4,284	2,761	28,032
pmpm fee	$144.97	$158.97	$136.60	$179.24	$155.88	$170.67	$144.13	$110.78		$140.26	$132.49	$162.03	$154.10
% health care	85.2	91.8	94.6	86.6	86.4	78.4	84.5	88.7		82.7	69.9	77.7	79.9
% admin.	13.5	11.4	11.6	11.6	12.7	11.2	14.7	11.1		13	17.6	22.3	14
% gross profit	1.6	-2.3	3.7	2.3	1.9	11.3	4.2	0.89		5.7	14.5	2	7.9
Physician visits/1000	5,578	N/A	3,841	4,097	4,503	2,635	3,344	4,669		3,787	3,985	5,320	4,679
1994 Enrollment	74,852	82,186	4,980	42,225	98,551	89,096	43,965	117,902	2,603	153,374	5,569	2,936	32,018
pmpm fee	$146.76	$165.82	$111.70	$185.01	$166.42	$174.47	$153.33	$172.96	$159.49	$126.16	$118.76	$169.62	$160.42
% health care	82.8	80.8	98.4	86.9	84	84.4	85.3	80.3	105.8	77.5	100.2	84.2	69.6
% admin.	14.7	11.5	14	11.3	13.8	10.5	15.3	16.9	15	14.4	15.8	21.7	13.4
% gross profit	3.6	8.2	1	2.7	1.7	6.4	2.9	4.6	-12.4	8.9	-13.2	-3.9	18.5
Physician visits/1000	3,383	5,919	3,654	3,898	4,783	2,954	3,631	4,960	3,153	2,676	2,072	2,284	5,110
1995 Enrollment	104,592	238,519**	15,829****	41,613	146,175	***	47,380	145,371	17,500	214,616	5,035	3,586	46,863
pmpm fee	$137.08	$140.60	$159.42	$175.05	$150.54		$143.00	$108.96	$153.54	$126.55	$124.49	$173.04	$142.60
% health care	82.4	85	79.6	88.5	82.3		81.4	79	80.7	76.7	99.1	82.1	84
% admin.	20	13	49.5	13.4	15.2		17.7	16	17	15.8	22.4	28.3	15.8
% gross profit	3.2	3.2	9.5	-0.01	3.7		3.7	6.25	0.03	8.4	-0.18	-0.08	0.09
Physician visits/1000	3,193	N/A	2,964	4,336	3,995		3,769	N/A	3,274	2,622	1,889	N/A	4,521

*per-member per month fee ** includes enrollment for previously separate Constitution Health Care ***CHC merged with Blue Care **** Cigna also has 115,773 "administrative services only" members

Source: Best's Managed Care Reports, 1995 for data through 1994, individual annual reports for 1995 data

costs, which includes HMO staff compensation, operating expenses, and marketing, has been growing since 1991.

The final financial statistic provided in the table is the percent of gross profits, which A.M. Best measures by taking income (before taxes and extraordinary items are subtracted) and dividing by total revenue. As the table shows, the profitability levels are typically below 5 percent, except for Prudential from 1991 through 1993 corresponding to the years of the company's low medical loss ratios.

The last row for each year includes a measure of utilization for each company -- the number of physician visits per 1,000 members per year. The table results show considerable variation in the range for this ratio -- from about 2,000 visits a year for some companies to more than 5,000 visits for others. In other words, in some plans each person sees a doctor an average of twice a year, while in other plans the average per person is about 5.5 visits.

Comparison Between Connecticut And Other States' HMOs

The committee also examined Connecticut's HMO experience in comparison with other states. Several components were examined and the data are presented in Table II-2 on the following page. The averaging done for each state weighted each company's market share of the state's HMO population and premiums. However, because in some states companies are writing much more Medicare business than Connecticut HMOs are to date, and those rates and utilization figures are typically higher, the committee used fees and hospital days with the Medicare business removed. The physician visit measure is not reported by type of population and therefore reflects visits by all members.

Components examined. As the table shows, Connecticut's experience with HMOs appears comparable with the other states examined. A summary of the categories in the table, by column, is discussed below:

Fees. Connecticut ranked 4th-highest of the nine states in terms of average monthly fees charged for each member covered. California had the lowest average fees, at $111 and Maryland the highest, at $160; Connecticut's average monthly fees were $134.

Medical loss ratio. The medical loss ratio is the percent of premium dollars spent on health care. New Jersey's HMOs spent the least on health care, an average of 78 percent of all premiums collected, while Minnesota's HMOs spent 93 percent. Connecticut's HMOs, by comparison, expended 84 percent of their premiums on health care in 1995. Some states, including Connecticut, set a floor for medical loss ratios for Medicare Supplement policies. Other states have discussed setting a similar standard for loss ratios for HMO business, but none has yet done so. In Connecticut, the medical loss ratio for Medicare Supplement plans is statutorily set at 65 percent, a standard that all Connecticut HMOs would have surpassed for 1995.

Table II-2. Comparison of State HMO Averages for 1995						
State	*(1) Average Monthly Fee*	*(2) Average Medical Loss Ratio*	*(3) Average Visits to Physicians per/1000*	*(4) Hospital Days per/1000*	*(5) Average Profits 1994-95*	*(6) Tax Status: %HMOs Non-Profit*
CA	$111	85.4%	3,621	189	3.3%	26%
CT	$134	84.2%	3,608	281	1.8%	44%
FL	$128	86%	4,181	334	2.4%	0%
MA	$151	90.1%	5,348	389	3.4%	60%
MD	$160	85.3%	4,375	268	3.6%	38%
MN	$132	93.3%	4,064	268	3.2%	100%
NJ	$142	77.6%	3,831	343	6.5%	18%
NY	$128	88.3%	4,071	320	3.7%	55%
TX	$132	91%	3,871	238	2.4%	13%

Source of Data: Best's Managed Care Reports, 1995 and 1996 Editions

Physician visits. A criticism of HMOs is they control health care utilization, including doctor visits, in order to save money. Certainly visits to physicians for each 1,000 members is a gross measure of how much members actually use this service. However, the results in this category lead to two conclusions. First, there is considerable variability among states, just as there is with individual plans that make up each state's average. Second, the results in column (3) in the table indicate that in 1995 no state reported an average of less than 3,600 physician visits per 1,000 members. The average for HMOs in Connecticut, California, New Jersey and Texas ranged from 3,608 visits per 1,000 members to 3,871. In three other states, enrollees visited physicians between 4,000 and 4,300 times per 1,000 members, while Massachusetts HMOs averaged more than 5,000 visits per 1,000 members. (One HMO in Massachusetts registered a rate of more than 10,000 visits to physicians per 1,000 members, double any other HMO's rate).

Hospital days. Another measure of utilization the committee compared is length of hospital stays. Variability also exists, to a lesser extent, with this measure as displayed in column (4) of the table. California ranked the lowest in hospital days used -- 189 days per 1,000 members, or 0.19 days for every member. Massachusetts, on the other hand, had the highest hospital usage with every 1,000 members using 389 days, or 0.39 days for each member. Connecticut ranked 5th-highest on hospital usage, with a ratio of 281 days per 1,000 members or .28 days per member.

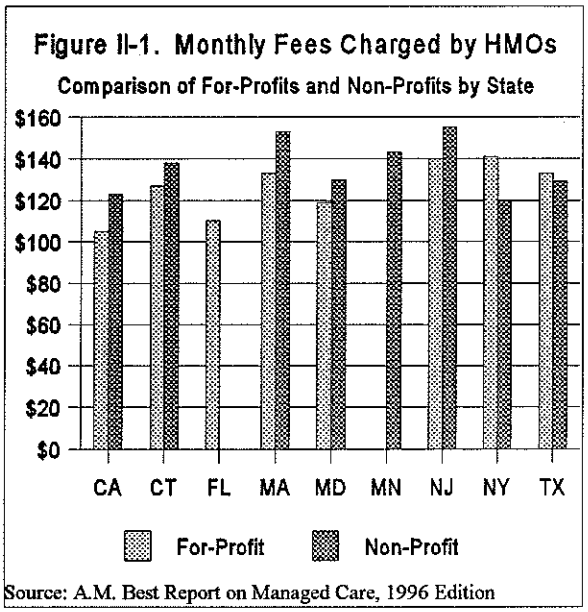
Profitability. There are different ways to examine how profitable a company is. The program review committee used gross profitability, one of the measures compiled by A.M. Best Company, and the same one used in Table II-1 in comparing Connecticut's HMO profitability. The program review committee averaged this measure for both 1994 and 1995 for all states' HMOs, to lessen some of the one-year variability in profits. As the results in column (5) of Table II-2 show, Connecticut's HMOs had the lowest profit levels of the nine states compared with an average two-year profit level of less than two percent. New Jersey's HMOs experienced the highest average profit levels of 6.5 percent over the two years.

Tax status of HMOs. Often critics of managed care claim HMOs deny needed health care services to improve their profits for shareholders or to increase executive salaries. Not all HMOs are for-profit, but increasingly many are. Especially as federal funds to establish and expand HMOs have dried up, these entities depend on investors to raise capital. The tax status of the HMOs for the states was compared and the results are shown in the extreme right hand column of Table II-2. Except for Minnesota -- which has only non-profits because for-profit HMOs are banned by law -- and Florida -- in which all the HMOs are for-profit -- all of the states have a mixture of both types of entities.

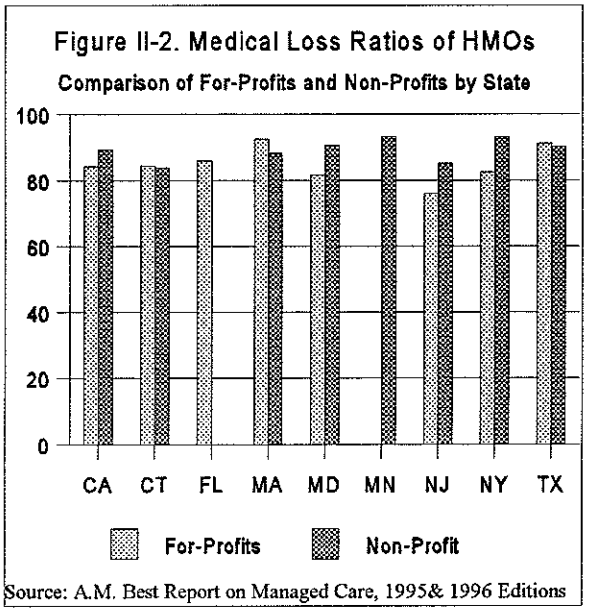
An analysis of tax status and its impact on the way HMOs do business is shown in Figures II-1, II-2, II-3 and II-4 on the following page. The program review committee recognizes the data are only for 1995, and for some states the data are based on very few HMOs of one type or the other, and, therefore, cautions against reaching any hard conclusions based on the analysis. However, it does appear there are some differences in HMOs' fees, medical loss ratios, hospital stays, and the number of times members visit physicians, depending on whether the HMO is a for-profit or not, but the differences vary among measures and states.

Figure II-1 shows that in five of the seven states with both types of HMOs, the non-profits had higher average fees. In California and Massachusetts the difference between the fees was quite substantial, while in the other states the gap in fees was not as great. In New York and Texas, the for-profit companies had higher fees. Figure II-2 shows that in four of the seven states with both types of HMOs, non-profits expend a greater portion on health care, while in Massachusetts and Texas, the for-profit companies spent a higher percentage.

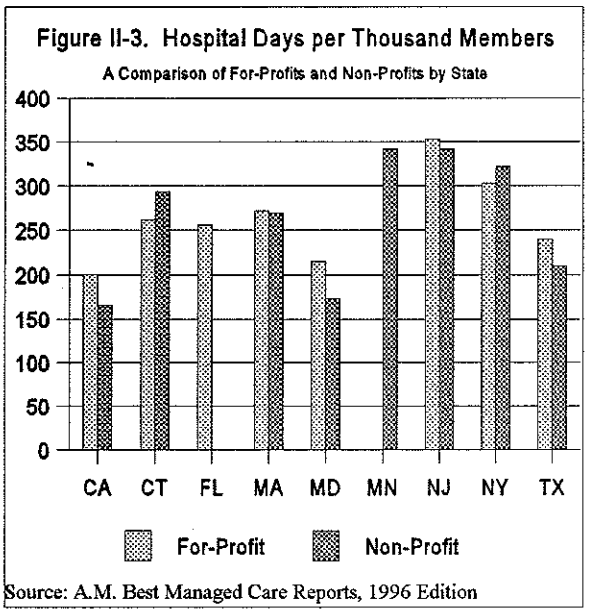
Figure II-3 shows that in five of the seven states with both types of tax-status HMOs, members of for-profits incurred slightly longer hospital stays than those members enrolled in non-profits. However, by the other utilization measure -- physician visits -- non-profit members had higher utilization. As Figure II-4 shows, in six of the seven states with both profits and non-profits, the members of non-profits saw their physicians more than those in for-profit organizations.



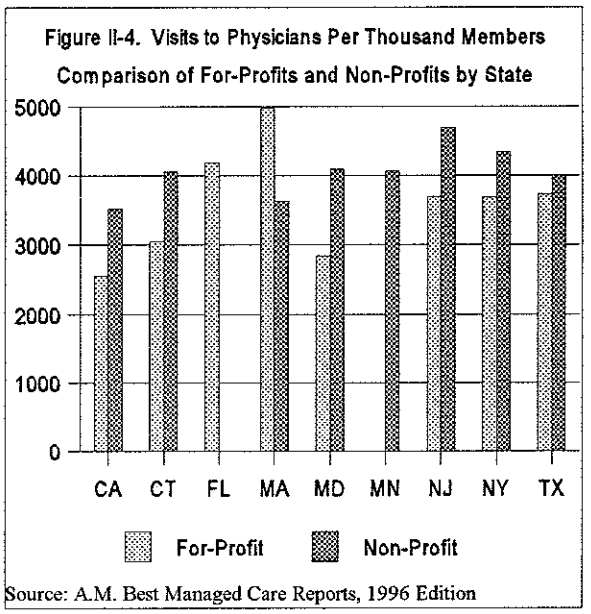
Source: A.M. Best Report on Managed Care, 1996 Edition



Source: A.M. Best Report on Managed Care, 1995& 1996 Editions



Source: A.M. Best Managed Care Reports, 1996 Edition



Source: A.M. Best Managed Care Reports, 1996 Edition

Analysis of the state comparative data are summarized as follows:

- *non-profits expend a higher percentage to health care expenses in four of seven states;*
- *members of non-profit HMOs typically experienced more physician visits than members of for-profits in six of seven states;*
- *members of for-profit HMOs stayed somewhat longer in hospitals than members of non-profit HMOs in most of the states compared; and.*
- *non-profits charge higher monthly fees than for-profits in five of the seven states with both tax status HMOs.*

Thus, the committee found there may be some variations between for-profits and non-profits, but the differences between the two vary from state to state and measure to measure. In some states, members of non-profits may use more services, but they also may incur higher fees. The program review committee believes that purchasers should be allowed to decide which type of plan is right for them by judging their utilization statistics compared to the fees charged, and therefore does not recommend any standard for medical loss ratio, hospital stays, or other utilization measures, nor does the committee recommend requiring only one tax status for HMOs.

The committee concludes, however, that purchasers need to be provided with this type of information so that they can make informed decisions based on comparative data. **Therefore, the program review committee believes the Department of Insurance should compile utilization measures, profitability data, and tax status for all Connecticut health plans in the report card for consumers as outlined in a recommendation in Chapter IV.**

CHAPTER III : REGULATORY STRUCTURE

- There are a number of agencies that have responsibility for overseeing the delivery and financing of health care including the Departments of Public Health, Insurance, and the Office of Health Care Access.

- The Department of Insurance has primary responsibility for regulating health maintenance organizations in the following areas:

  - financial solvency;
  - licensure;
  - rate approval;
  - policy and forms approval, including ensuring that benefits meet state and federal mandates; and
  - assuring that the HMO has an internal dispute resolution system for handling complaints.

- Current regulatory structure and agency responsibility are appropriate.

- Documents currently submitted to the Department of Insurance by HMOs relate to insurance coverage, and are best reviewed by the insurance department.

- The Department of Insurance is diligent in its oversight role in examining policies and documents before they are approved for use.

- Greater protection is needed to prevent HMO insolvencies, because there is no HMO guaranty fund, and regular insurers must currently maintain higher financial reserves than HMOs.

- HMOs must have rates approved by the Department of Insurance, but group rates of regular health insurers do not.

Key Points

- Some judicial interpretations of the federal Employee Retirement Income Security Act (ERISA) have been inconclusive. Other court decisions clearly prohibit some state activities such as: mandating employers to pay for benefits; regulating terms and conditions of health plans; or directly taxing or assessing employer health plans.

- It is difficult to determine how many Connecticut residents are covered by ERISA self-funded plans. One national study indicates that about 40 percent of employees receive their benefits through a self-insured plan, but two other surveys indicate that the percentage of Connecticut employees may be less.

- ERISA offers employers a legitimate way to escape state mandates through self-funded plans. If increasing regulation prompts more employers to self fund their plans, the state loses the ability to oversee those plans and the ability to garner revenues from premium taxes.

Chapter III

Regulatory Structure in Connecticut

Federal role is limited. Health insurance, like other types of insurance enterprise, is a matter for states, not the federal government, to regulate. Thus, the controls and oversight over managed care is considered a state activity. (One major exception to state regulation, through the federal Employment Retirement Income Security Act legislation, will be discussed in some detail later in this chapter.)

While the federal government does not control health insurance or managed care, there are federal influences. In the early 1970s Congress passed legislation, known as the Federal Health Maintenance Organization Act, to promote HMOs as an alternative to regular health insurance plans through government loans and grants to those HMOs that could meet certain federal standards. As the federal monies became less available, HMO interest in becoming federally qualified waned.

Currently, renewed interest by the federal Health Care Financing Administration in contracting with HMOs to cover Medicare clients has spurred HMO interest in those federal standards once again. However, only those HMOs interested in contracting with the federal government, or in obtaining federal loans or grants, must be federally qualified and meet those federal standards. Thus, most of the regulation of health care is the responsibility of the states.

State Agency Responsibility

There are several state agencies that have some responsibility for regulating aspects of health care in Connecticut, including its financing and its delivery. The *Department of Insurance* has the largest role in regulating health insurers and health maintenance organizations to ensure they meet licensing and financial solvency standards. The *Department of Public Health* licenses and regulates health professionals, and inspects and licenses any facility that provides health care services. The *Office of Health Care Access* is mandated to collect information on all managed care organizations, and maintain and report on hospital budget and utilization data. Until 1992, OHCA had a role in setting some hospital rates, but since that time rates have been set by the market and competition. (The *Department of Social Services* is responsible for overseeing managed care for Medicaid clients, but Medicaid managed care is not included in the scope of the study.)

In 1994, the legislature created the *Connecticut Health Care Data Institute*, which it envisioned would be the principal recipient and generator of health care data. The legislation authorized the institute to maintain a statewide database on all inpatient and ambulatory encounters, track expenditures and health outcomes, and evaluate and distribute information concerning certified health plans and their providers.

Efforts to have the health data institute become operational have not been successful. An appropriation of $400,000 was made for the institute in the Office of Health Care Access' budget and a national search for a director was begun in late 1994. The search was halted because there was a proposal to eliminate the institute in the governor's 1995 budget. All but $5,000 of the $400,000 was returned to the Office of Policy and Management.

A steering committee, made up of relevant executive branch agencies and the governor's office, was formed in FY 96 to develop a clearer role for the institute, and a memorandum of agreement was developed but was never signed by all the parties. In February 1996, the first quarter's FY 96 appropriation to the institute was returned, and none of the statutory duties outlined for the institute was undertaken.

Department of Insurance

Primary regulatory responsibility for health care plans lies with the Department of Insurance. It oversees all insurance companies, including health insurers, to ensure financial solvency. The department also reviews and approves rates and policies, handles complaints, and oversees companies' conduct in the marketplace.

Any organization that acts like an insurance company by taking and spreading risks must be regulated by the insurance department. The department's oversight includes health maintenance organizations (referred to in Connecticut statutes as health care centers) because they accept the risk of providing health care to their subscribers in return for premiums or per-person fees. Preferred provider organizations, individual practice associations, and third-party claims administrators, on the other hand, are not required to be licensed because they do not accept and spread risk. Instead, they contract with insurers, health maintenance organizations, or self-funded employers. Table III-1 outlines the regulatory components on various health care organizations.

The program review committee found the current regulatory structure and agency responsibility is appropriate, and makes no recommendation for any realignment of regulatory responsibility nor an expansion of licensure to other entities that are not insurance companies or HMOs.

Table III-1. Comparison of Regulatory Components On Various Health Care Organizations.

Regulatory Component	*HMOs*	*Health Insurance Companies*	*PPOs*	*Utilization Review (UR) Companies*
Licensure	Required to be Licensed by Insurance Dept. as a Health Care Center	Required to be Licensed as an Insurer by the Insurance Dept.	PPO Not Required to be Licensed; Each individual health care provider must be licensed by the DPH	Required to Be Licensed as a UR Company by the Insurance Dept.
Rate Approval	Rates must be approved by Insurance Dept. for all plans	Rates for Individual policies and Medicare Supplement policies must be approved; Rates for group policies do not	Rates are not examined or approved	Rates or Fees charged are not Examined or approved
Capitalization Requirements	Minimum $1.5m. required for licensure and must maintain net worth of 2% of premium up to $150m and 1% of amount over $150m ; Dept. looking for projections to profitability	Health insurers are required to be licensed under Life and Health and requires minimum $1m capital and $2m surplus	Not licensed -- No requirements	No minimum capital requirements; Annual license fee of $2,500
Guaranty Fund	No guaranty fund exists for HMOs	Life and Health Guaranty Fund. Each insurer is assessed for the fund . Assessments may not exceed 2% of the average premiums of 3 previous years	No guaranty fund	No guaranty fund -- not providing insurance or medical services to individuals or groups
Location of Corporation	Must be incorporated and domiciled in CT as a health care center	May be domiciled elsewhere; Must be licensed as an insurer in CT	No License Required	May be located anywhere -- must have a CT License
Approval of Forms and Policies	Insurance Dept. Must approve all forms and policies used for HMO products sold in CT	Insurance Dept. Must approve all policies and forms for all health insurance products sold in CT	Not licensed - No approval of forms	No forms approval necessary, but statute requires that each ur company use written clinical criteria and review procedures with appropriate practitioner involvement

(Continued on the following page.)

Table III-1. Comparison of Regulatory Components On Various Health Care Organizations.

Regulatory Component	*HMOs*	*Health Insurance Companies*	*PPOs*	*Utilization Review (UR) Companies*
Dispute resolution procedure	Must be part of form submission; Insurance Cmsr. May hold hearing if either party requests	Not required as part of form submission, but the Insurance Dept's Consumer Affairs Division is statutorily required to **receive and review** all complaints concerning insurance, including claim disputes	Not required	Statutory dispute resolution and appeal procedure; Insurance Dept.statutorily required to **receive and investigate** all complaints against ur companies; Cmsr. May hold hearings under certain circumstances
Premium Tax	1.75% of premiums	1.75% of premiums	No premiums generated; no tax	No premiums generated; no tax
Provider Network	Insurance Department does not review or approve. HMOs required to file copy of provider networks with the Office of Health Care Access for information purposes. No enforcement authority.	No requirement	PPOs are required to file network listings with OHCA	no networks, but must show compliance with statutory requirements that all health professionals at UR company have current license from state in U.S.
Board of Directors Representation	If HMO is non-profit, 25% of Board members must be providers, including 1 physician and 1 dentist, and 25% shall be eligible subscribers; if HMO is for profit, a mechanism for members to participate in matters of policy and operations shall be required	No requirement	Not licensed, no requirement	No requirement
"Hold Harmless" Clause	Must be contained in written contracts with providers	No requirement	No requirement	No requirement

Source of data: LPR&IC, 1996

HMOs are like insurance companies. They establish plans of coverage, market health plans, ensure that services are included as a covered benefit before approving the service or payment, and pay providers according to contract. Therefore, the insurance department is the appropriate state agency to regulate HMOs. Except for Kaiser Health Plan, which has on-site health services, health maintenance organizations do not see patients directly and are not the direct providers of health care. They contract with doctors, hospitals and other providers to do that. The direct provision of those services, and the facilities where they are performed, are monitored and licensed through the Department of Public Health.

Extent of HMO Regulation

Health maintenance organizations are regulated for financial solvency in all states, and in the vast majority of states, that function is performed by each state's insurance department. In Connecticut, the statutory responsibility and financial expertise for regulating health maintenance organizations, including solvency and rates, already exists at the insurance department, and the program review committee believes that function should remain there.

Policy review. Connecticut statutes require that, prior to licensure, health maintenance organizations submit to the insurance department: sample provider and group contracts; evidence of coverage forms with included and excluded benefits; and the plan's internal grievance procedures. Any policies, forms, or documents must also be submitted and approved by the Life and Health Division with the Department of Insurance before a plan may be marketed in Connecticut.

The division also examines the HMO's complaint handling procedure, as well as the material on coverage given to the subscriber or enrollee to ensure that they "do not contain provisions or statements that are unfair, inequitable, misleading, deceptive, or which encourage misrepresentation" (C.G.S. § 38a-182(a)). Policies are also examined to ensure they meet the statutorily mandated benefits. (A more detailed listing of statutory benefits and coverages is contained in Appendix B). It is important to note that the department reviews for statutory mandate compliance, but makes no further judgement on the coverage of benefits nor on the adequacy of the network or types of providers.

The program review committee believes that the documents currently submitted are related to insurance coverage, and are best reviewed by the Department of Insurance. Further, the committee found the Department of Insurance is diligent in its oversight role in examining policies and documents before being approved for use. The program review committee staff reviewed all HMO policies on file at DOI and found there is frequently correspondence between the department and the HMO before a policy, or a new product, is approved. Typically, the DOI staff will advise a change to clarify confusing language, or inform the insurer or health plan that a mandated benefit must be included in plan before it can be offered.

Absent a mandate for a single payor system, for universal coverage, or for a standardized package of health benefits, health plans are developing and marketing insurance products that respond best to employer and consumer needs for adequate benefits at an affordable price, and the insurance department is the best agency to regulate those products.

The program review committee believes the purchasers of the health plans are the best judges of the levels of quality and access standards they wish, and does not recommend that a state agency establish those for them. While the committee believes that better information should be provided to consumers on quality and utilization issues, legislating those standards is unwarranted and premature in a health system that is changing rapidly. Additional requirements may constrict health plans' abilities to develop new products, to recognize new technologies and assess their impact on health care, and form new networks. Such changes may also stifle innovation, artificially raise the costs, and restrict availability of health insurance coverage.

In approximately 35 states, the health agency also has a regulatory responsibility, typically for monitoring a plan's utilization patterns, accessibility to physicians, and other quality of care issues. However, without pre-established criteria on what quality measures should be, health agency involvement would be duplicative, and would add no real value to the regulatory process for approving health plans. In fact, Texas has recently gone from two-agency jurisdiction to one because of regulatory confusion.

Licensure and Rate Setting

Examination for HMO license. The Financial Examination Section within the Department of Insurance is responsible for reviewing all applications for HMO licensure. Currently, a principal examiner in the department, who is a certified financial examiner, conducts the financial reviews of HMOs, both for initial licensure and annual review for solvency.

HMOs are required to be Connecticut-domiciled companies (required to be incorporated in Connecticut and keep all their financial documentation in Connecticut). This helps regulators keep track of HMOs' business in Connecticut, and ensures that their financial records are accessible. In addition, the Financial Examination Section reviews the HMO's proposed business and financial plan to ensure that the business partners have some expertise in the running of an HMO. The business plan must document that it has a claims-payment system, as well as how it will handle complaints.

The Financial Examination Section also requires three-year enrollment, revenue, and expenditure projections. The application must also include information on how the HMO will contract with physicians, hospitals, and other providers, and what the credentialing procedure (selection process) is for providers.

Financial requirements. To obtain and keep a license, HMOs must show that they have enough capital to start and maintain operations, so that they do not become insolvent and leave

subscribers without health care coverage. The Connecticut DOI reviews each HMO's financial condition to ensure that it meets the statutory capital and net surplus requirements.

Once an HMO becomes licensed, it does not have to be relicensed, but it must file quarterly and annual financial statements so that the insurance department can monitor its financial condition. In other areas of insurance -- property/casualty and regular life and health insurance -- the National Association of Insurance Commissioners tracks the financial condition of companies, and places financially troubled companies on its "watch" list. The organization does not yet collect data on the financial conditions of HMOs, although it is planned. Thus, the ongoing financial surveillance of HMOs is at the state level.

The initial criteria an HMO license applicant must meet are the capital requirements. The ***minimum*** capital required by statute is $1.5 million, (raised from $1 million in 1990 via Public Act 90-68). Second, the HMO must maintain a minimum net worth of either: 1) $1 million; or 2) two percent of the first $150 million of premiums plus one percent of premium revenues over $150 million, whichever is greater.

The program review committee compared Connecticut's financial requirements with other states' through the National Association of Insurance Commissioners (NAIC) data. Of the 39 states for which NAIC has data, Connecticut's requirements are similar to 12 other states. Twenty-two states have less stringent financial requirements than Connecticut or leave the determination of financial adequacy up to the insurance commissioner. Three other states have somewhat higher capital requirements. New Hampshire's requirements are substantially higher, requiring HMOs to have and maintain net worth requirements of $6 million.

In Connecticut, health insurers that are not HMOs (indemnity health plans) must maintain a $2 million surplus, even though they are also assessed for a guarantee fund which is tapped in the event that an insurer becomes insolvent. HMOs do not contribute to a similar guaranty fund, although Connecticut statutes require a plan for remaining Connecticut HMOs to take over the business of an insolvent HMO. The committee believes that despite the statutory plan to protect consumers whose HMO collapses financially, subscribers need greater protection. Especially given that HMOs do not contribute to a guaranty fund, and that NAIC does not yet have a financial "warning" system for them, HMOs must maintain greater ongoing capital reserves to protect subscribers.

Thus, to ensure HMO consumers greater protection, and to equalize the surplus requirements between HMOs and regular insurers, **the Legislative Program Review and Investigations Committee recommends that HMOs be required to maintain a net worth of at least $2 million, the same as indemnity health plans.**

Rate setting. All HMO rates must be filed with and approved by the insurance department before the health maintenance organization can apply them to subscribers. Regular health insurers only file rates for individual and Medicare supplement policies, not group health policies, which make

up most of their business. The department may deny any approval of rates, if the amounts are excessive or inadequate for the coverage, or if they are unfairly discriminatory.

Except for very large employers, HMOs are prohibited from experience rating, where a group's health claims experience is considered in establishing the rate. Instead, HMOs must provide community rating, although it may differentiate pricing based on the demographics of the group including age, sex, and geographic location. The community rating requirement for HMOs was initiated as part of the federal Health Maintenance Organization Act for those HMOs wanting to become federally qualified. Connecticut laws governing HMOs, which in large part adopt the federal standards, also include this requirement.

Rate review. The Life and Health Division also examines HMO's proposed rates to ensure they are not excessive, inadequate or unfairly discriminatory. The current director of the Life and Health Division, an actuary, conducts the rate reviews. No rates are disapproved outright, according to the director, but there may be negotiation between the department and the HMO before the proposed rates are approved. Rate filing guidelines issued by DOI state that HMOs with approved rates already on file may change the rates, pending approval from the department, as long as the premium quote forms explicitly state they are still subject to DOI approval. If the rates are not approved exactly as submitted, the HMO would have to make payment adjustments to the enrollees. The DOI guidelines also require that HMOs provide pricing differentials for small employer groups.

HMO rates are filed in per-month per-member (or per family) format, and the same rate is charged for each member, or family in that plan. However, there are a wide variety of actual rates charged because HMOs, like other health insurers, offer multiple plans. The plans' rates can vary depending on:

- the co-pay to the enrollee for office visits, outpatient services, and the like;
- the level of benefits covered;
- the size of the group purchasing the plan, and sex and age of enrollees; and
- the geographic area of the state.

The program review committee believes that approval of HMO rates is an appropriate function for the insurance department, given some version of community rating is required for HMOs, and therefore makes no recommendation in this area.

ERISA and Its Limits on State Regulation

A major constraint on expanding state regulation over health care plans is ERISA. The federal legislation creating ERISA was designed to regulate private sector pension and employee benefit plans. Specifically, ERISA was enacted to establish equitable standards of plan administration, minimum standards of plan design, and fiscal responsibility. Congress' rationale was that ERISA's uniform standards would enable large interstate corporations to predict the legality of proposed actions without the confusion of varying state laws. A key provision in ERISA is a clause which reserves to the federal government, to the exclusion of the states, the right to regulate employee benefit plans.[4]

As a result, ERISA provides employers broad preemption from state regulation. The preemption states the act "shall supersede any and all state laws insofar as they may now or hereafter *relates* (sic) *to* any employee benefit plan." This clause essentially exempts all such employee benefits plans, including their health insurance coverage, from state regulation. However, state laws regulating insurance, banking, and securities are spared from the preemption through ERISA's "savings" clause. Under this clause, states may regulate conventionally insured employee benefit plans but may *not* regulate plans that self fund or bear the primary insurance risk.

One significant policy effect of this, as noted by the U.S. Supreme Court, is that it creates two classes of employee health plans. Plans funding coverage through insurance are, in effect, subject to state regulation, while those that self fund are completely beyond state jurisdiction. For example, states cannot require employers to provide health care coverage, but they can require that all health insurance policies sold in the state include specific benefits. The regulatory framework differs depending on whether the employer purchases its health care coverage from an insurer or if it self funds its health plan. Employers who obtain their health care coverage from an insurer must purchase health plans as dictated by legislative mandate. However, employers who self fund their benefits may design their own health plan coverage.

Since 1974, hundreds of court cases have been filed by various parties attempting to clarify the meaning of ERISA. The U.S. Supreme Court once remarked that ERISA "was not a model of legislative drafting."[5] As a result, courts have struggled to interpret ERISA, and depending on the issue involved the results have been inconsistent conclusions. (A fuller explanation of ERISA and judicial interpretations are contained in Appendix C). Other judgments have been more clear-cut. Table III-2 lists some of the state activities that have been addressed and significantly limited by the courts. As the table shows, courts have determined that states are prohibited: from mandating employers offer or pay for health insurances, from requiring self-funded plans meet statutory

[4] Benefit plans are statutorily defined to include "the purchase of insurance or otherwise provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death."

[5] Metropolitan Life Ins. Company v. Massachusetts 471 U.S. at 739.

mandates, requiring those health plans be taxed; or that data on health care use, quality, or costs be submitted.

Table III-2. Judicial Interpretation of ERISA on State Activities.

State Activity	Current Authority
Require employers to offer or pay for benefits or insurance for employees.	Prohibited.
Regulate the terms and conditions of employee health plans.	Prohibited (except through regulation of traditional insurance carriers).
Directly tax or assess employer health plans.	Prohibited (except indirectly by taxing traditional insurance carriers).
Require uniform data collection to report on use, cost, and quality information.	Allowed for insurers. Prohibited for self funded plans.
Require health plans to use uniform claims procedure.	Allowed for insurers. Prohibited for self funded plans.
Require health plans participate in purchasing pools.	Allowed for insurers. Prohibited for self funded.

Source: National Governors' Association Report 1994

Gauging the impact of court decisions on ERISA is difficult, and so too is determining the extent to which Connecticut employers and employees are subject to its jurisdiction, and thus beyond state regulatory reach. A recent study conducted for the U.S. Department of Labor estimates that nationwide 40 percent of all employees receive their health benefits through a self-insured plan. However, two other surveys of private sector employers indicate that the percentage of employees covered by self-funded plans in Connecticut may be less than the national average.[6]

Thus, it is uncertain exactly how many private sector employees in Connecticut are covered by self-funded health plans, but it is most likely at least one-quarter, and probably higher. However, plans that are self-funded do not necessarily translate to sub-standard coverage for enrollees. The U.S. Department of Labor also found that, despite the differences in regulatory oversight, substantial similarities exist between self-insured and fully insured plans in their demographics, benefits, and premium costs.

[6] The Personnel Management Services Annual Survey of Connecticut Employers indicates about 23.5 percent of Connecticut's 1.5 million private sector employees are covered by self-insured plans, while the National Employer Health Insurance Survey indicates about 31.2 percent of Connecticut's employees are in self-funded plans.

The legitimate escape offered to employers through ERISA should signal some caution to policy makers that stringent regulation of insured health care plans may only trigger more employers to self-insure, thereby avoiding any costs incurred through increased mandates or reporting requirements. When this happens the state not only loses the ability to oversee those plans, but the ability to garner the revenues from premium taxes as well.

Accreditation

In addition to government regulation, a recent movement toward self-monitoring in managed care has begun. In response to demands for quality services provided by health maintenance and utilization review companies, organizations designed to accredit these companies have developed. The leading accreditation organization for utilization review is the Utilization Review Accreditation Commission (URAC). The National Committee for Quality Assurance (NCQA) accredits prepaid managed care organizations and all structural forms of HMOs.

Accreditation of utilization review. URAC was established in December 1990 by the American Managed Care and Review Association, which is a trade association for utilization review firms, PPOs, and HMOs. The URAC accreditation process was developed to bring uniformity into the utilization process and provide an alternative to state regulation. The URAC accreditation process begins with a desktop review of a detailed application. If URAC staff are unable to verify or interpret the information given, they will conduct an on-site inspection for which the applicant organization will pay expenses.

The URAC standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities. URAC standards specify that the utilization review organizations shall collect and use only the information necessary to certify the admission, procedure or treatment, and length of stay. Medical records may be requested retrospectively for purposes such as auditing, quality assurance, and evaluation of compliance with the terms of the health benefit plan or utilization review provisions.

URAC standards. In most respects, the accreditation standards are similar to Connecticut's utilization review statutory requirements. In fact, Connecticut statutes allow the insurance commissioner to accept the accreditation as having met the statutory criteria for utilization review companies. The accreditation standards require accessible hours and specific certification, appeals procedure, and qualified personnel. The URAC standards require that reviews be conducted in a timely manner. For most cases, certification determinations are to be made within two working days of receipt of the necessary information. Utilization review organizations may conduct ongoing reviews of inpatient stays but may not conduct daily review of such stays. The organization must have procedures in place for providing notification of its determinations. The utilization review organization is also required to have procedures to address the failure of a health care provider, patient, or their representative to provide the necessary information for review.

Accreditation standards require that utilization review staff be properly trained, qualified, and supervised. Written clinical criteria and procedures are to be established with appropriate involvement from physicians and periodically evaluated and updated. Standards require that all decisions not to certify be reviewed by available specialists who are board certified or board eligible. There must be written documentation of an active quality assessment program.

If the organization meets the minimum criteria for accreditation, the reviewer's recommendation is forwarded to an accreditation committee, comprised of representatives from various national medical associations and societies, which reviews the information with all organizational identifiers deleted. If the accreditation committee decides to recommend accreditation, the application is sent to the board of directors for final approval. Accreditation is granted for a two-year period. There are 129 utilization review companies licensed by the state of Connecticut. Of those, approximately 39 have URAC accreditation.

National Committee for Quality Assurance. Established in 1979, NCQA was originally governed by the HMO industry. In late 1989, the Robert Wood Johnson Foundation awarded NCQA a grant to develop as an independent entity. NCQA is a nationally recognized organization that purchasers, regulators, and consumers can use to assess managed care plans. Eligible organizations must: 1) provide comprehensive health care services to enrolled members through a defined benefit package in both ambulatory and inpatient settings; 2) have been in operation and actively caring for members for at least 18 months; and 3) have access to essential clinical information about their patients. To meet NCQA standards, an organization must have a well-organized, comprehensive quality assurance program accountable to its highest organizational levels.

NCQA standards. NCQA measures health plan performance primarily through two methods -- accreditation reviews and report cards. At the time of application, an organization fills out a preliminary information form which contains a detailed description of the plan's delivery system including information about quality assurance, utilization management, and credentialing activity. NCQA uses this information to determine the size and composition of the review team and the duration of the on site review. The accreditation review is based on 50 standards in six main categories: 1) quality management; 2) physician credentialing; 3) members' rights and responsibilities; 4) preventative health services; 5) utilization management; and 6) medical records.

The NCQA review team typically consists of an administrative reviewer and two or more physician reviewers. The first and most intensive area of NCQA review targets an organization's own internal quality control systems. NCQA establishes compliance with its standards by a thorough review of an organization's quality assurance program description and related policies, procedures, studies, projects, and monitoring activities. In addition, NCQA reviews quality assurance committee and/or governing body meeting minutes, interviews key staff, and tracks issues uncovered by the quality assurance system to ensure resolution and documented evidence of quality improvement.

The accreditation process also includes a thorough review of an organization's credentialing system. NCQA also requires a periodic performance appraisal of its providers to include information from quality assurance activity, risk and utilization management, member complaints, and member satisfaction surveys.

Among the NCQA standards for utilization management are requirements that:

- the review decisions are made by qualified medical professionals;
- the organization has written utilization management protocols based on scientific evidence;
- there are adequate appeal mechanisms for physicians and for patients;
- decisions and appeals are processed in a timely manner; and
- the utilization management system monitors for under- and over-utilization.

Compliance with these standards is confirmed through a review of utilization reports, committee minutes, individual files, as well as interviews with relevant staff.

Another NCQA requirement is that an organization have a system for resolving members complaints and grievances. This system must aggregate and analyze complaint and grievance data and use the information for quality improvement.

Once the review team determines compliance with each of the NCQA standards, it prepares a summary report of its findings. The report is reviewed by NCQA staff and an oversight committee of physicians. The oversight committee makes compliance determinations for each of the NCQA standards as well as for the overall accreditation decision.

Accreditation period. Plans can achieve three levels of accreditation: full, one-year, or provisional. Plans that meet all the NCQA standards receive full accreditation which lasts three years. One-year accreditation status is awarded when, in NCQA's judgement, the organization is in substantial compliance with most of the standards but still has significant areas of non-compliance. If a plan receives a one-year accreditation, NCQA provides the plan with a specific list of recommendations and reviews the plan again within one year to determine if the organization improved enough to move up to full accreditation. Plans with partial compliance but without deficiencies that pose significant risk to quality of care are awarded provisional accreditation. These plans are resurveyed within one year and given the opportunity to upgrade to either one-year or full accreditation. Accreditation lapses for provisionally accredited plans that fail to correct the areas of deficiency. Plans that fail to meet the NCQA standards are denied accreditation.

Eight states currently use NCQA accreditation as part of their quality oversight requirements: Pennsylvania, Rhode Island, Florida, Nevada, Vermont, South Carolina, Oklahoma, and Kansas. The NCQA accreditation status among Connecticut health plans is provided in Table III-3.

Table III-3. NCQA Accreditation Status of CT Health Plans: December 1996

	Full 3 year.	*One Year*	*Initial review pending*	*In progress of scheduling review**
PHS	✓			
US Healthcare		✓		
Kaiser		✓		
BlueCare	✓			
Connecticare	✓			
Medspan			✓	
Oxford	✓			
Cigna		✓		

* New plans must be in existence and operating for at least 18 months before a site visit can be scheduled.
Source of data: NCQA Accreditation Status List - December 1996

As of December 1996, seven Connecticut health plans had NCQA accreditation status. One health plan has a site review pending. As mentioned earlier, NCQA accreditation is a strictly voluntary process. Health plans choose whether or not they would like to be reviewed by NCQA. Some health plans believe there are limitations and/or potential problems with NCQA accreditation. For example, changes in accreditation standards over time may make it difficult to compare the accreditation statuses across plans. There is also significant time and effort spent by the health plan to prepare for NCQA review which is intensified by long waiting lists and delays for site visits. Finally, there is concern that less is expected from newer plans while larger, older plans may be examined more critically. NCQA itself has recognized the limitations of its accreditation process. While NCQA accreditation is the most thorough examination of health plan quality currently existing, it simply determines whether basic protective mechanisms are in place for the plan's members. It does not measure performance or examine results or outcomes.

Health Plan Employer Data and Information Set (HEDIS). Larger employers were also looking for more outcome-based measures than could be provided through the NCQA accreditation process alone. These employers, with the cooperation of NCQA, in 1993 developed a system of health plans indicators known as the Health Plan Employer Data and Information Set (HEDIS). While still not a pure report of outcomes, HEDIS provides a set of uniform standardized performance

measures designed to document the quality and value of health plans and, in time, allow for outcome comparisons among competing plans.

Because of employer demands, more than 300 health plans nationwide are currently using HEDIS to report on their performance. This standardized measurement underlies most report cards now being issued to consumers by employers and plans. To date, NCQA has released HEDIS 2.0 in 1993 and HEDIS 2.5 in 1995. HEDIS 3.0 will be released in January of 1997. HEDIS 2.5 contains a collection of more than 60 performance measures in the areas of quality of care, enrollee access and satisfaction, membership and utilization, finance, and descriptive information on health plan management. Table III-4 lists some key HEDIS measures for examining these categories. HEDIS 3.0 is expected to address the needs of a broader population (including Medicaid and Medicare), and have more outcome measures related to acute and chronic care and incorporate a standard member satisfaction survey.

Table III-4. Selected HEDIS measures

Quality/Access:	These measures assess the plan delivery of preventive care and services related to chronic and acute diseases including: childhood immunizations, cholesterol screening, mammography, pap smears, prenatal care visit, diabetic retinal exams, follow-ups after major affective disorder hospitalization, number of members visiting providers, asthma admission rate, and low birth weight rate.
Utilization:	These measures review health plans' coronary bypass rate, angioplasty rate, cardiac catheterization rate, hysterectomy rate, prostatectomy rate, laminectomy rate, cesarean section rate, obstetrical hospital stay, re-admission for chemical dependency, and hospital days/1,000 enrollees.
Physician Network:	Measures in this area evaluate the stability of plan physician networks through physician turnover rates and the percentage that have obtained certification in their field.
Membership/Finance:	These measures examine a plan's membership disenrollment, medical loss ratio, administrative loss ratio, revenue requirements per member per month, and tier rates.

Source of data: National Committee on Quality Assurance

Managed Care Regulation in Other States

The last segment of this chapter focuses on regulation of managed care entities in other states. Although there is a certain level of uniformity in the regulations from state to state, wide variability also exists. The most common and heavily regulated entity is the health maintenance organization. The following is an attempt to identify basic regulatory requirements but specific criteria varies from state to state and is described in more detail below.

The states selected for this profile were chosen for one or more of the following reasons: a long-standing history of regulating HMOs; mentioned by health care literature as being forerunners in regulation; and/or their proximity or other similarity to Connecticut. Based on these criteria, the following states were selected: California, Minnesota, Texas, Florida, Maryland, New York,

Massachusetts, and New Jersey. The information was compiled using statutes, regulations, comprehensive reference materials, interviews, and surveys. Table III-5 lists the various regulatory measures in effect in the selected states. A more detailed description is contained in Appendix D.

Table III-5. Comparison of Other State Managed Care Regulation

	CA	FL	MN	TX	CT	NY	MA	MD	NJ
Primary Reg. Agencies	Corporation	Insurance/ Health	Health	Insurance/ Health	Insurance	Insurance/ Health	Insurance	Insurance/ Health	Insurance/ Health
Certificate of Authority/ License term	Until Revoked	Until Revoked	One Year	Until Revoked	Until Revoked	Until Revoked	Until Revoked	One Year	Until Revoked
Regular Mandated Examinations	3yr	3yr	3yr	3yr	5yr	3yr	2yr	3yr	3yr
Regulation of:									
Marketing Practices	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physician/Enrollee Ratio	✓+	✓	✓	✓			✓	✓	✓
Distance/Time to Care	✓+	✓+	✓+	✓+				✓	✓+
Quality Assurance Plan	✓+	✓+	✓+	✓+		✓+	✓+	✓+	✓+
Grievance Process	✓+	✓+	✓+	✓+	✓	✓+	✓+	✓+	✓
Data Collection	✓	✓	✓	✓		✓	✓	✓	✓
Enrollee Representation	✓		✓		✓	✓		✓	
Physician Credentialing		✓	✓	✓				✓+	
Insolvency Protection	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nonprofit Status Required			✓						
Accreditation		✓							

✓+ Specific regulations
Source of data: LPR&IC 1996

Overview. This discussion is a limited overview of other state regulation. In addition to enabling statutes and regulations, other sources of authority are used to govern HMO operations. From time to time, regulators will supplement their regulations with written policy statements or internal office policies that are developed to deal with specific issues.

HMOs are regulated on the state level often by more than one state agency. Typically, regulatory supervision is shared by departments of insurance and health. In a few instances, other state subdivisions may be charged with some supervisory duties. Insurance regulators assume principal responsibility for the financial and consumer aspects of HMO operations. Health regulators focus on quality of care issues, utilization patterns, and the ability of participating providers to provide adequate care.

Licensure is required and typically obtained by applying for a certificate of authority or license and payment of licensing fees. Applications are usually processed by the insurance department and, among other items, include the following documents: sample provider and group contract forms; evidence of coverage forms; financial statements and feasibility plan; description of service areas; internal grievance procedures; and the proposed quality assurance program. Some regulators require enrollee participation in determining HMO policy .

In addition to licensing requirements, managed care entities are also required to adhere to various statutory and regulatory mandates. All states prohibit misleading, confusing, and unjust advertising and marketing practices. Regulators tend to require policy, forms, and documents be filed with and approved by the regulatory body prior to use. Many times plans must provide details on how services can be obtained through the HMO network and a telephone number at the plan to answer additional questions. A few states require HMOs to maintain a sufficient ratio of physicians to enrollees, however, most do not indicate what constitutes an adequate ratio. Accessibility standards for distance and waiting times are referenced in a limited number of HMO regulations. In addition, a few states require a system for reviewing the credentials of physicians or impose some minimum requirements on their staff and contracting providers.

All states require the establishment of a grievance procedure to assist in the resolution of the enrollee complaints. Some states often specify how these grievances should be handled. Enrollees must be informed of their right to a hearing when they join the HMO. Typically, regulators require that each HMO form a grievance committee that hears complaints. Decisions by the committee may be appealed within the HMO and, if necessary, the state may step in to hear the complaint.

All states have solvency protections in place. Most establish specific capital, reserve, and deposit requirements for HMOs to protect consumers and other interested parties against insolvency. Before a certificate of authority will be issued, an initial net worth requirement may be set. After issuance, a minimum net worth must be maintained usually as a percentage of annual premiums. A deposit may be required to protect the interests of HMO enrollees or to cover the administrative costs

if the HMO goes into receivership or liquidation. Only one state (Minnesota) restricts the formation of HMOs to nonprofit entities.

In most states, HMOs are required to include "hold harmless" clauses like the one required in Connecticut. States often require HMOs to establish contingency plans for insolvency that allow for the continuation of benefits to enrollees during the contract period for which premiums have been paid. If necessary, insurance departments will call for HMOs to take further precautions to safeguard enrolled benefits. This may include the purchasing of additional insurance entering into contracts where providers promise to continue to provide services in the event the HMO ceases operation, setting aside additional insolvency reserves, or securing letters of credit.

State regulators employ a number of methods to make sure the HMO stays in compliance with the law after it is licensed. Regulators may conduct specialized inquiries which often examine HMO finances, marketing activities, and quality assurance programs. These are also conducted to determine HMO financial solvency and statutory compliance.

Another common compliance check is to impose data collection and/or reporting requirements. Typically, annual reports must be filed with the regulating agency. These may include audited financial statements, a summary of enrollee grievances, or schedule of premium rates. Regulators in some states also require quality assurance programs that evaluate among other things, preventive care activities, program administration, provider credential review, utilization review procedures, risk management, provider payment mechanisms, accessibility of services, medical records, claims processing procedures, and management information services. Finally, some states require an HMO to obtain an independent external review of its quality assurance program from approved review agencies such as the National Committee for Quality Assurance.

National Association of Insurance Commissioners

Often states rely on national organizations to create prototypes or models of regulations that can be adapted or modified to meet the needs of particular jurisdictions. Probably the best-known organization involved in developing regulations is the National Association of Insurance Commissioners (NAIC). It first developed model regulations for overseeing HMOs in the early 1970s, and by the early 1980s 27 states had adopted the model or portions of it. In 1994, the NAIC drafted additional HMO model regulations in five areas: credential review; utilization review; quality assurance; grievance procedures; and provider contracting. Two of these models -- credential review and quality assessment (the name was modified since 1994) -- were adopted at the annual meeting of NAIC in June 1996, while the remaining model acts are still being revised.

CHAPTER IV : CONSUMER PROTECTION EFFORTS

➢ Consumers are generally satisfied with managed care but efforts are still needed to educate consumers about health care services as well as protecting and assisting consumers when they have a problem with their plans.

- The state should build on the existing efforts made by health plans and national accreditation organizations and work to compile a uniform data set, assess the accuracy of the data, and ensure that it is released in a format that is useful to consumers.

- Consumers must have a clear understanding of detailed benefits and exclusions and internal plan process *before* a person signs on with a plan.

➢ The number of complaints per 1,000 HMO enrollees received by the Department of Insurance has decreased from 0.5 to 0.3 percent from 1993 to 1995.

➢ Most health care complaints deal with interpretation, communication, and administration.

➢ Overall, the insurance department handles complaints in a prompt manner, and to the extent of its regulatory authority, services consumers well. However, its automated coding system for complaints is deficient.

➢ There is a perceived threat to confidentiality in two areas: 1) broad interpretation of contractual access to provider records; and 2) disclosure of personal information to third parties such as employers.

- New federal regulations pursuant to 1996 legislation and revised guidelines from the National Association of Insurance Commissioners will address these issues.

Chapter IV

CONSUMER PROTECTION EFFORTS

Customer Satisfaction

Managed care has become more prevalent with about one million of the state's population now belonging to HMOs compared to less than 600,000 only four years ago. According to employers and some unions, employees have gone to managed care willingly because of the reduction in paperwork and less out-of-pocket expenses. They claim that when given a choice between traditional indemnity and managed care plans the vast majority of employees will choose managed care for these same reasons.

Once an HMO is chosen, most people appear to like their managed care plans. Standards of accreditation show very high rates of satisfaction. To be accredited by the National Committee on Quality Assurance (NCQA) each HMO must annually survey its members on satisfaction, and while there is no passing grade, NCQA does require corrective action if subscribers rate the HMO poorly. In Connecticut, most HMOs have received satisfaction ratings above 90 percent.

Because HMOs themselves often conduct the surveys, the results are often questioned. A more objective measure of Connecticut's satisfaction level with managed care are the results of a recent CONNECTICUT POLL, jointly conducted by the Hartford Courant and the University of Connecticut's Institute of Social Inquiry. The poll asked 500 state residents several questions concerning health care and satisfaction levels. Sixty-seven percent of those polled stated they have insurance through some type of managed care organization. As shown in Table IV-1, satisfaction results were the same with managed health care as with other coverage.

In addition, HMO complaints received by the Connecticut insurance department have declined even as the population in these organizations increased. Further discussion on the number of health care complaints is provided later in this chapter. A decreasing number of complaints with HMOs, especially when the overall population enrolled in these plans has grown dramatically, suggests a more satisfied clientele. Elsewhere, a further endorsement of managed care occurred when California residents rejected two propositions on the 1996 ballot in that state that would have increased regulation of managed care organizations.

Table IV-1. Connecticut Residents' Satisfaction With Health Care Coverage			
Ratings	*Satisfaction – Overall*	*Satisfaction – Managed Care*	*Satisfaction – Other Types of Coverage*
Excellent	31%	31%	31%
Good	44%	44%	44%
Fair	19%	18%	19%
Poor	4%	4%	4%

Source of data: Connecticut Poll #163, Release 6, April 15, 1996

Satisfaction ratings with HMOs are not as high among sicker populations. A 1995 study conducted by the Harvard School of Public Health shows that non-elderly sick or disabled people in managed care plans were generally more dissatisfied with their health care than similar people in other health plans, although a percentage was also dissatisfied with fee-for-service.

Given the general support of managed care, the program review committee believes that improving processes for consumers to seek corrective action when they have a problem is the appropriate regulatory route and makes recommendations to this end. The committee believes this is a better direction than to change managed care while it is still evolving. It would be premature to make radical changes to managed care now -- when it appears to be improving the affordability of health care overall, increasing the coverage statistics for Connecticut residents, and receiving generally good satisfaction ratings from the public.

Although the program review committee concludes that consumers are generally satisfied with managed care, some regulatory changes are needed. Efforts are still needed to educate consumers about health care services as well as protecting and assisting them when they have a problem with their plans. Government, accreditation agencies, employers/purchasers, and health plans themselves all have a role to play in these efforts. In addition, consumer groups and the media scrutinize, evaluate, and rate plans which also help individual enrollees with health care decisions. This chapter summarizes current consumer protection mechanisms available both through government and private organizations, cites where these efforts may be deficient and gaps still exist, and offers recommendations for increased education and protection for the health care consumer.

Member Complaints and Grievances

When medical costs were less rigorously scrutinized health plans paid for most procedures or tests physicians ordered. Now that health plans are more active in managing health care costs, beneficiaries at times disagree with their health plan over whether a benefit or type of treatment is covered. The following describes the grievance and appeal procedures available to consumers.

There are a number of places consumers may submit complaints about health care services. He or she may submit complaints to the health plan itself for internal review or to the Department of

Insurance's Division of Consumer Affairs. If they have a complaint concerning a particular physician, consumers may submit complaints to the Department of Public Health. In addition, complaints relating to ERISA plans may be brought to the attention of federal Department of Labor.

HMOs' internal consumer complaint process. Connecticut law requires each agreement issued by an HMO contain a description of the enrollee grievance procedures and afford any aggrieved party the right to complain to the state insurance department. The committee reviewed the consumer complaint process outlined in the HMO subscriber agreements filed at the insurance department. (A synopsis of HMOs' internal grievance procedures are summarized in Appendix E.) In general, subscriber agreements reviewed state a member may use the grievance process to address issues including, but not limited to: the denial of claims; interpretation of benefits, plan policies and procedures; or issues with participating providers. The process may be used by member enrollees or their participating provider on their behalf. Almost half of all HMOs have established time limitations for submission of complaints. This ranges from 90 days to a year from the time the incident occurred.

In general, HMOs offer a three-tiered complaint process. The first stage is usually an attempt by a member service representative to reach an informal resolution. Most HMOs will take the initial complaint either by phone or in writing. A few require the complaint to be in writing and at least one HMO indicates what information should be included. Half of the agreements do not indicate what their response time will be in the initial stage, but the ones that do claim response times ranging from 48 hours to 30 days. Some indicate when and how notification will be delivered.

If the determination at the first level is not satisfactory, the member may go to the second stage. This is usually a reconsideration or review of the informal resolution. Most HMOs require members to submit a written request for this stage review. In addition, there are usually some time restraints for submission. At this level the complaint is reviewed by a management committee which may include the executive director, medical director, and/or other member services staff. The management committee may conduct a hearing or formal presentation of the facts. These hearings are usually held at the discretion of the company but occasionally are at the request of the member and, in at least one instance, automatically held. The turnaround time for hearings held in the second phase is between 14 and 30 days although a few state that a determination will be made within a "reasonable" time. Member notification of the final determination is usually in writing and a few will indicate the reasons for the disposition.

A member may appeal the second level review. The member must file a written request, within a certain time period of receiving notice of the second level resolution of the complaint. This level appeal is reviewed by senior management or a subcommittee of the board of directors. There may be a hearing or presentation made, usually at the discretion of agency. The member may or may not be invited to present further testimony at the hearing. The response time for this stage is between 14 and 60 days. Notification is made in writing. Finally, almost all of the HMOs indicate that further review is available through the Connecticut Department of Insurance.

The committee requested appeals information from all Connecticut HMOs. Table IV-2 shows the appeal outcomes for the eight that replied. As the table shows, the number and percentage of appeals upheld and overturned varies from plan to plan. Overall, 65 percent of the reported 443 appeals heard by an internal HMO committee were upheld. Thirty-four percent were reversed and one percent were partially upheld/partially reversed.

Table IV-2. HMO Internal Appeal Decisions: 1995

HMO	Appeals Decided*	Upheld	Reversed
Connecticare	41	26 (63%)	8 (20%)**
MDHealth	175	120 (69%)	55 (31%)
USHealth	4	1 (25%)	3 (75%)
Kaiser	12	10 (83%)	2 (17%)
Oxford	8	3 (38%)	5 (62%)
Cigna	17	6 (35%)	11 (65%)
BC/BS	140	94 (67%)	46 (33%)
PHS	46	26 (57%)	20 (43%)
Total	443	286 (65%)	150 (34%)**

* Reflects the total of upheld and reversed decisions.
** Additional 7 appeals were partially upheld/reversed.
Source of data: LPR&IC Data Request to HMOs

Department of Insurance complaint process. The Division of Consumer Affairs within the Department of Insurance responds to insurance complaints and inquiries from consumers, businesses, and others who have general or specific questions or problems with insurance. The division may ask complainants to state their complaint in writing if the problem is complex, although, if quickly resolvable, staff may handle a complaint over the phone. The complaint is then either referred to the insurance company with a request by the division for a written reply or an examiner may phone an insurance company representative and request information pertaining to the complaint. According to department staff, companies usually respond within 30 to 60 days but may take longer depending on the complexity of the case.

Information supplied by an insurance company is carefully reviewed. On occasion, complaints may be referred to another division for support or additional information. The examiner checks the company's filed materials as well as the department's bulletins and statutory guidelines for non-compliance. If the examiner finds that an error has been made by the insurance company, the division

informs the company and asks for a written reply outlining what corrective action will be taken. Once received, the examiner informs the complainant of the problem and the action that will follow. If no problem is detected, the complainant is provided with an explanation of why the complaint is invalid. In addition to the paper file, basic information relating to the complaint is coded and filed in the department's automated system.

U.S. Department of Labor. As mentioned earlier, there is one category of complaints outside the purview of the Department of Insurance. Complaints relating to self-funded plans are subject to ERISA regulation. ERISA requires that employers providing health benefits also provide a mechanism for employees to contest plan decisions about coverage and claim denials. Employers usually delegate this authority to their plan administrators due to their greater medical expertise. When an employee and the health plan disagree, the plan administrator typically makes a judgement as to whether a given benefit is covered or treatment is necessary. Thus, an employee will file a claim or request approval for a procedure, and the plan administrator will approve or deny the claim.

Every ERISA employee benefit plan is required to provide written notice to any participant or beneficiary when his or her claim for benefits under the plan has been denied as well as afford a participant whose claims have been denied a reasonable opportunity to a full and fair review of the denial. As described above, most health plans establish an internal dispute resolution process for enrollees to appeal these decisions. When self-insured complaints arrive at the state Department of Insurance, department staff will try to intervene whenever possible on behalf of the participant, but their jurisdiction is clearly limited. They also provide information and direct the complainant to the U.S. Department of Labor.

Under its authority to protect employee welfare plans, the U.S. Department of Labor can investigate problems that appear to be plan-wide and affect multiple participants. ERISA does not, however, explicitly empower the Department of Labor to pursue administrative or judicial remedies on behalf of individuals disputing health plan benefit denials. Due to limitations on its legal authority and resources, the Department of Labor generally does not act on individual disputes between a participant and the plan, recommending instead that dissatisfied plan participants seek legal advice.

Under ERISA, enrollees dissatisfied with their health plan's decisions can sue to enforce their rights either to have a claim paid or the benefit provided. Many courts have required exhaustion of internal plan claim procedures as a prerequisite to bringing suit for benefits under ERISA. However, the application of the exhaustion doctrine is left to the discretion of the trial court and as will be discussed in Chapter VI, there are limitations to ERISA remedies.

Department of Public Health. Another measure of consumer protection is the licensing and oversight of physicians and other health care providers by the Department of Public Health. The majority of activities within the Department of Public Health involving the regulation of health care delivery are consolidated within the Bureau of Health Systems Regulation. The bureau contains the Division of Medical Quality Assurance which has overall responsibility for the regulation of health

care professionals. The division investigates complaints against regulated health care providers and, as warranted, may take disciplinary action, restrict an individual's practice, or revoke their right to practice in the state.

Most complaints are received by mail and from a toll-free consumer hotline located within the unit. Complaints are referred by consumers, health providers, health care institutions, professional organizations, local authorities, and other sources. In addition, the division may initiate its own investigations. Upon receipt of a complaint, it is assigned to an investigator who, after collecting evidence and other pertinent information, prepares an investigative report. This report is then reviewed by a division supervisor and legal advisor to determine whether there is sufficient evidence to pursue disciplinary action or whether the matter should be dismissed. If grounds for disciplinary action are found, the department may seek to settle the case informally with a consent agreement. If the case cannot be settled, formal charges are filed. The licensing board or commission that regulates that profession hears the evidence in an administrative hearing and renders its decision on the evidence. This decision may include disciplinary action against the licensee. Licensees who have been subject to a disciplinary action involving a period of probation are monitored by the division to ensure they comply with the terms of the action. All disciplinary actions taken must be reported to the federal National Practitioners Data Bank (discussed below).

Table IV-3 presents the number of complaints received against physician and surgeons from calendar years 1990 to 1995. As can be seen, the number of complaints received have increased dramatically while the number of licensees has somewhat decreased. Table IV-3 also presents the number of complaints received per 100 licensees which has increased as well. According to the department, there are a few reasons why complaints against physicians and surgeons are on the rise. First, media reporting on malpractice cases stimulates the number of complaints the department receives. Second, the medical profession itself has become more vigilant and willing to bring forth problematic providers. Finally, consumers as a whole have become a more litigious group and may file an administrative complaint to support their position in a judicial lawsuit.

Table IV-3. Physician/Surgeon Complaints Received Per 100 Licensees: 1990-95.

	1990	*1991*	*1992*	*1993*	*1994*	*1995*
Total Licensed	10,964	10,045	12,215	11,041	11,938	12,100
Complaints Received	156	153	169	288	319	276
Per 100 Licensees	1.42	1.52	1.38	2.61	2.67	2.28

Source of data: Department of Public Health

National Practitioner Data Bank. Operational since 1990, the National Practitioner Data Bank (NPDB) was established to ensure that unethical or incompetent medical practitioners do not compromise health care quality. The data bank is administered by the U.S. Department of Health and Human Services and maintains records of disciplinary actions taken against health care practitioners and malpractice payments made on their behalf.

Specifically, the databank acts as a central repository of information about: 1) malpractice payments made on behalf of physicians and other health care practitioners; 2) licensure disciplinary actions taken by state medical boards against physicians; and 3) adverse professional review actions taken against physicians and other health care practioners by hospital and other health care entities, including health maintenance organizations, group practices, and professional societies. This information is made available upon request to hospitals, health maintenance organizations, state licensing boards, professional societies engaged in peer review, and other quality assurance and credentialing authorities to serve as an information source and to assist them in their professional review activities.

The data bank tries to ensure that complete and accurate information is in the reports it receives and in the information it provides to queries. Each practitioner about whom a report is filed receives a copy. If a practitioner believes a report is misleading or inaccurate, he or she may file a personal statement which is disclosed whenever the data bank record is disclosed. He or she may also formally dispute the factual accuracy of the report and request that the reporting entity change it. If the reporting entity fails to change the report to the satisfaction of the practitioner, he or she may request a review of the matter by the Secretary of the Department of Health and Human Services. The Secretary will investigate and will modify or void the report as necessary.

Table IV-4 provides NPDB information on the number of malpractice and reportable actions per 1,000 physicians in various states. Reportable actions include licensure revocations, suspensions, reprimands, clinical privileges revocation, suspensions and other similar actions lasting longer than 30 days.

With respect to malpractice data, it is important to keep in mind that the number of malpractice reports may have been affected by the "corporate shield" effect. This occurs when individual practitioners who would otherwise be reported to the data bank may have worked out settlements in which they are not named. If a malpractice payment is made for a hospital rather than a practitioner, for example, no report is filed with the data bank. The extent of the corporate shield effect cannot be conclusively measured with the available data.

However, even considering the effect of the "corporate shield" both in Connecticut and nationwide, it is much more likely that a physician would incur a malpractice settlement or award than be disciplined by the state licensing board. As the table points out, the malpractice activity is three to four times as frequent as the state disciplinary actions taken.

Table IV-4. NPDB Reports Per 1,000 Physicians, by Year, Type, and Work State.								
	Malpractice Reports Per 1,000				*License & Privilege Action Per 1,000*			
	1991	***1992***	***1993***	***1994***	***1991***	***1992***	***1993***	***1994***
Maryland	11.07	13.56	13.49	14.61	4.06	5.44	7.80	10.87
Connecticut	12.88	16.17	14.22	13.60	4.22	3.71	4.22	4.84
Massachusetts	13.85	16.49	14.82	13.19	2.18	2.84	3.10	4.97
Minnesota	15.77	16.51	14.18	15.35	2.96	7.51	7.51	6.24
California	19.78	25.24	25.38	27.27	4.09	3.86	4.43	5.24
U.S. Mean	***23.87***	***26.21***	***26.13***	***27.60***	***5.21***	***5.83***	***6.51***	***7.58***
Florida	23.94	27.02	28.49	29.97	7.87	7.43	6.80	7.76
New York	29.66	34.28	34.08	35.90	2.15	3.27	4.47	5.46
Texas	32.59	33.05	32.43	35.40	6.50	7.45	6.28	10.69
Source of data: NPDB								

Department of Insurance: Complaint Analysis

The committee reviewed complaints drawn from the insurance department's automated system. Acknowledging that there is no single definition of managed care, the committee staff examined the department's coding system and selected certain categories in an attempt to capture the spectrum of complaints involving managed care. Analysis of these data is presented below and in greater detail in Appendix F.

Complaint ratios and trends. In 1995, the Department of Insurance received 1,578 complaints related to health plans. Close to 80 percent (1,243) of these complaints involved insurance companies compared to 19 percent (299) dealing with HMOs. Internally, HMOs reportedly handled 361 grievances in 1995 according to their annual filings with the insurance department. This number represents less than half of one percent (0.4 %) of HMO enrollees. This low ratio is also reflected in Table IV-5 which presents the number of HMO complaints received by the insurance department since 1993 in relation to the number of HMO enrollees.

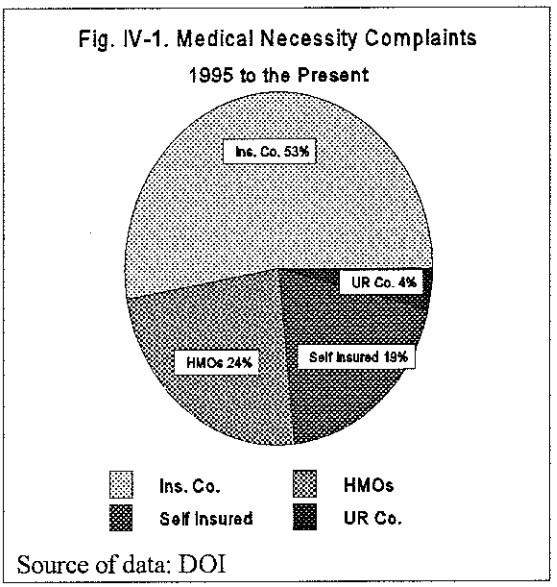
Table IV-5. Comparisons of HMO Complaints Received by DOI to HMO enrollees			
	1993	1994	1995
Number of DOI complaints against HMOs: per 1,000 enrollees number (%) "justified"	337 0.5 31 (9%)	238 0.3 19 (8%)	299 0.3 35 (12%)
Total Number of HMO Enrollees	711,543	750,257	1,027,079

Source of data: LPR&IC analysis

In fact, complaints per 1,000 enrollees actually declined from 0.5 to 0.3 percent from 1993 to 1995. Of the complaints handled by the insurance department only a percentage are considered "justified." As the ratios show, less than 1 percent of enrollees have filed complaints through either the internal HMO grievance process or the insurance department. *The committee thus found that this low complaint ratio indicates that poor customer treatment by HMOs is not a widespread problem.* This is also supported by employers interviewed stated they rarely, if ever, heard complaints from their employees about HMOs.

"Medical necessity" complaints. While the insurance department deals with a wide variety of complaint issues, one of the most difficult is the issue of medical necessity. For the full calendar year 1995 to September 1996, the program review committee identified 236 complaints received by the department that were coded as "medical necessity" complaints.

Figure IV-1 shows the breakdown of all "medical necessity" complaints identified by the committee. As illustrated by the figure, slightly more than half of all medical necessity complaints are made against insurance companies, while 24 percent are filed against HMOs. Another 19 percent of the complaints are made against self-insured plans. Four percent of the complaints name a utilization review company.



Source of data: DOI

Of the 236 "medical necessity" complaints, 26 are still open. Committee staff conducted a file review of all closed "medical necessity" complaints involving HMOs (39) and utilization review companies (7). Of the remaining 164 closed "medical necessity" complaints, the committee staff examined a random sample of case files relating to insurance companies (6) and self insured plans (3) for a total of 55 "medical necessity" complaints reviewed by the committee. Specifically, the staff looked at both the content of the complaints and the process

used to resolve them. Information was compiled on the nature, origin, and final disposition of each. The results are analyzed below.

The complaint files reviewed contained general correspondence between the department, insurance companies, and complainants. The files typically included: the complainant's written description of the problem; an examiner's request to the insurance company for a written reply and information pertaining to the complaint; the company's response indicating its position; and the notification letter to the complainant of the examiner's determination of whether the company's response supports its position or, if appropriate, its corrective action.

Nature of complaint. Although each case is unique in its circumstances, the committee found that complaints coded as "medical necessity" fall into a few broad categories. One common type of problem involves the interpretation of covered benefits. This type of complaint usually occurs when the member seeks coverage for a service that he or she believes is medically necessary but is not covered under the schedule of benefits. Examples of this include:

> **Example:** Subscriber agreement states that coverage includes up to 30 physical therapy visits. Health plan approves and pays for four visits. Member wants payment for 20 visits. Member feels since the contract says 30 visits are allowed she is entitled to coverage up to the limit.

> **Example:** Member's dependent is required to get Hepatitis B shots to participate in college program. Health plan denies claim on the basis of contract exclusion. Health plan does not reimburse for requirements of school or other third parties.

Another common type of medical necessity complaint is when the member had services rendered without prior authorization and the plan then denied or reduced coverage. Finally, a small number of medical necessity complaints actually deal with disagreements about diagnosis or appropriate course of treatment.

In its analysis, the committee found that 60 percent of the "medical necessity" complaints dealt with the interpretation of coverage. Several of the complaints requiring interpretation of coverage involved physical therapy, mental health, or substance abuse. Another 18 percent concerned authorization problems. Many of the complaints regarding pre-authorization fell in the area of emergency treatment and referrals to out-of-network providers. Of the files reviewed, 11 of the 55 complaints involved differing medical opinions. Two involved differences in diagnosis, and nine dealt with differences in the course of treatment.

In some instances, a complaint will involve a number of these issues. This is illustrated in the following case example.

Example: Patient has a history of heavy and painful menstrual cycle. After a conservative approach with drug therapy fails, doctor schedules a transvaginal hysterectomy. Patient enters hospital and gets prepped for 11 a.m. surgery. Twenty minutes prior to surgery, doctor's secretary calls to inform patient that health plan will not authorize operation. Patient's doctor contacts the health plan's medical director to discuss the case. According to the complainant, the medical director was prepared to approve the operation until he found out the patient's age. Because the patient was not yet 30 but rather 26 years old, the health plan denied authorization. The patient was released from the hospital without the procedure. The patient appealed the denial, and the health plan sought a second opinion. The second opinion concluded that the patient did in fact need the hysterectomy. The health plan reversed its denial and authorized the operation. In the meantime, the patient was billed for the hospital prep work completed during the first canceled procedure. The health plan intervened and assumed the expenses. The patient received the surgery and was not charged for any hospital costs.

This case illustrates many of the problems of the "medical necessity" complaints. This example also illustrates the circumstance of dealing with patients who do not fall within the medical protocol guidelines. It is unclear from the paper file if and when the doctor sought authorization prior to the first scheduled procedure. It is unknown whether the treating doctor was aware of the health plan's medical protocols, including the age criterion. It is also unclear why the health plan initially approved the procedure prior to knowing the patient's age. In handling this case, the insurance department did not intervene in the medical decision making but rather monitored that the health plan's internal appeals process was followed.

Complaint handling. *The program review committee found that in the cases requiring interpretation of coverage, the insurance department relies on the schedule of benefits offered in the particular health plan.* Problems involving denial or reduction in coverage for services already incurred are a bit more complex. Usually, the issue in these cases is whether the plan received a claim without having authorized the services. The plan may pend or hold claims to investigate whether an authorization actually does exist or should have been given. If an authorization for services ultimately is given, the claim is paid. If no authorization is forthcoming, the claim is denied. The plan may occasionally pay the claim even without an authorization if circumstances exist such as certain emergencies, an urgent problem out of the area, or it is a first instance of a new member not complying. *In these cases, the committee found that miscommunication and misunderstanding was the major problem. In cases of prospective denial or reduction of coverage, the committee found that health plans generally respond to the member with the exact contractual language upon which it bases its denial of coverage.*

Again, the more complex problem arises when there is a difference of medical opinion as to the diagnosis or treatment. In these cases, the department determines whether the health plan handled the cases according to its internal medical appeal procedures. It does not make or override medical

decisions. In its response to complainants, the department informs the complainant that the issue is out of its purview and sometimes suggests the complainant seek legal counsel. It is important to note, however, there are times when a service may be considered medically necessary but the plan does not cover it under its schedule of benefits.

The committee examined the final disposition taken by the department and found that although the department has several coding options for complaints, they generally have four outcomes. Complaints are either determined in favor of the complainant or in favor of the licensee. Otherwise, the problem is negotiated or a compromise found more or less to the satisfaction of the parties. Finally, there are instances when the department determines it does not have jurisdiction or the authority to override a medical decision. If the complaint is outside its purview, the department would likely suggest that the complainant seek legal advice.

In the cases reviewed by the committee, 56 percent were determined in favor of the company, 14 percent in favor of the complainant, 13 percent had a negotiated compromise, and in another 13 percent the department had no jurisdiction. There were two cases in which the final determination was unknown or unclear.

Complaint status. Table IV-6 provides the status of all "medical necessity" complaints drawn from the insurance department's automated system. Of the cases that have been closed, 117 files were coded as "furnished information" or "satisfactory explanation." In general, more "medical necessity" complaints were coded as unjustified (the licensee's position is correct) than justified or questionable. In a few instances, a company voluntarily reconsidered its position in favor of the complainant even though statutory, regulatory, or contractual support existed for their initial position.

While the department has a basic procedural structure for complaint handling, the committee found that its automated coding system is deficient. First, the codes are not mutually exclusive and thus do not aptly describe the status or complaint outcomes. In addition, there is a fair amount of examiner discretion and autonomy in the handling and coding of complaints. As a result, there appears to be no uniform policy on coding complaints. For example, while some complaints are coded as "unjustified", other similar complaints are coded as "satisfactory explanation", which does not indicate whether the complaint was justified or not, unless the paper file is examined. **Therefore, the program review committee recommends the Department of Insurance re-examine its coding system. Specific codes should be developed to deal with health insurance complaints. Written definitions for each code should be provided to department staff and training given to implement a uniform coding system to facilitate tracking of complaint trends and outcomes.**

Periodic analysis of these codes will allow the department to identify problem areas and entities. It should also help the department evaluate its regulatory action in response to complaints. Although the existing automated system does allow for some analysis, it is limited because of the deficiencies of the coding method. Currently, the department informally keeps track of trends. Given the lack of uniformity in present coding, however, accurate tracking would be difficult.

Table IV-6. Final Status of All Medical Necessity Complaints: January 1995 - October 1996.			
DOI Status Code	**ALL CLOSED "medical necessity" complaints**	**HMOs**	**UR**
Justified	10	3	-
Unjustified	41	10	-
Questionable	12	3	-
Furnished Information	57	6	4
Satisfactory Explanation	60	14	2
No Action	10	-	-
Voluntary Reconsideration	18	2	1
Cross Reference	2	1	-
Total	210	39	7
Percent Reviewed by LPR&IC	26%*	100%	100%

* Incudes nine complaints against insurance companies and self insured.
Source: LPR&IC analysis of DOI documents

Overall, the program review committee found the insurance department handles complaints in a prompt manner, and to the extent of its regulatory authority, services consumers well. The department is vigilant of companies' timely responses and appears conscientious of keeping complainants informed of progress and complaint outcome. In addition to the coding changes for complaints, the committee makes other recommendations in Chapter V that will assist in the handling of "medical necessity" complaints and improve communication to the provider and patient.

In reviewing the nature of the complaints, the committee found that most complaints deal with interpretation, communication, and administration. The majority of complaints, as illustrated by the examples, involve consumer understanding of contract limits and exclusions as well as recognizing that health care coverage under a managed care system is not an absolute entitlement. Although the committee noted problems with the HMOs' internal appeals processes, the problems often involve providers having difficulty getting through voice mail systems, dealing with health plan "clerks", and verifying authorizations. While the committee noted one case where lost paperwork at the health plan delayed the appeals process, in general, complaints regarding the time frame limits set by the internal HMO grievance procedures were not found. Thus, the committee does not recommend statutorily mandating one uniform grievance process for all HMOs. However, the appeal process for complaints dealing with "medical necessity" or utilization review decisions can be improved. For these reasons, the committee made recommendations clarifying and strengthening the utilization review statutes as described in Chapter V.

Market Conduct

In addition to handling individual complaints against health insurers or HMOs, the insurance commissioner has statutory authority to undertake market conduct evaluations of insurance companies. The purpose of the evaluation is to detect violations of unfair trade practice laws and protect policyholders and claimants against companies operating contrary to insurance statutes and regulations. If the report concludes that the organization is operating in an illegal or improper manner or otherwise in violation of regulations, the commissioner has power to order the organization to correct deficiencies and/or face sanctions and penalties. Although the department has established a regular schedule for insurance companies, the department has only recently started performing market conduct examinations on health maintenance organizations.

The committee reviewed the most recent market conduct reports prepared for all health maintenance organizations. While there is some variation, most reports focus on the following evaluation areas: structure; claims administration; utilization management; quality assurance; and complaint/grievance procedures. A summary of the report highlights is presented in Table IV-7.

Table IV-7. Market Conduct Reports

HMO	*Licensed*	*Exam Date*	*Utiliz. Review*	*Sanctions*
Oxford	1993	7/15/95	Own	Yes
MDHealth	1987	3/22/93	Own	Yes
ConnectiCare	1981	2/3/95	Own	No
USHealth	1986	11/15/94	Own	No
*Constitution**	1990	3/24/94	Outside	Yes
PruCare	1988	4/30/95	Own	No
PHS	1975	12/9/93	Own	No
Kaiser	1979	4/15/95	Own	No
*Community Health**	1971	5/24/94	Own	No
Cigna	1985	3/6/95	Own	No
Suburban	1988	8/16/94	Own	Yes

* Has merged into Blue Cross Blue Shield HMO business since exam date
Source of data: Department of Insurance

State Monitoring

Although all Connecticut HMOs have quality assurance components within their organizations, external oversight of health plans is necessary in order to demonstrate their compliance with state laws and regulations and provide adequate information to consumers. Currently, external oversight of health plans is conducted by the insurance department through financial examinations, market conduct evaluations, and complaint investigations. Much information is collected by the insurance department about HMOs' financial solvency in their quarterly and annual statements. The annual reports also contain materials regarding many aspects of HMO operations including enrollment changes, percentages spent on medical costs and administrative expenses, profitability, and lawsuits filed. In addition, HMOs are required to file for approval all forms and policies related to the health care plans. Additional information is available through the department's market conduct evaluations and consumer complaint reports. Furthermore, information relating to the selection and composition of provider networks is maintained at the Office of Health Care Access. While these are essentially public documents, the information is not compiled or presented in an informative or usable consumer format.

Large employers have been the driving force behind the growing move to compare health care providers and plans on the basis of their performance. More and more, health plans are responding to the demands of purchasers and consumers to collect and publish quality-of-care information. Much progress has been made in this area especially through NCQA's HEDIS initiative.[7]

While several data sources exist, there is no compilation of this information in one place. The committee believes the state through the insurance department should lead the efforts to provide this considerably extensive and comprehensive information in summary form to consumers. Collecting this information will serve to both monitor HMOs and provide guidance to consumers in comparing and choosing health plans. The committee believes this would not duplicate employer or accreditation activities. The state should build on the existing efforts of health plans and national accreditation organizations and compile a uniform data set, assess the accuracy of the data, and ensure it is released in a format useful to consumers. The collection of existing materials along with some additional information will allow the state to prepare a "report card" on health plans.

Therefore, the committee recommends the Department of Insurance be responsible for collecting information from health maintenance organizations in the following areas:

- ***Organization and plan design*** **- including but not limited to basic descriptive information such as the type of HMO, tax status, the number of years in service, enrollment figures, and accreditation status;**

- ***Financial*** **- a health plan's premium change over three years, per-member per-month fees, percent of total premium revenues spent on medical care, and disclosure of how the plan compensates health care providers;**

[7] Health Plan Employer Data and Information Set (HEDIS) is a set of uniform standardized performance measures designed to document the quality and value of health plans.

- ***Utilization*** **- disclosure of the name or names of medical protocols being used and the utilization standards and rates for certain specific procedures chosen by the insurance department, the rate of physician visits per enrollee, the admissions to hospitals per enrollee, and the length of hospital stays per enrollee;**

- ***Medical management*** **- the provider-to-patient ratio by primary care and speciality care, the percent of primary and speciality care providers that are board certified, physician turnover rates, and whether local provider input was incorporated into protocols; and**

- ***Customer satisfaction*** **- the percentage of enrollees who re-enroll, the number of grievances received through the internal HMO grievance process, the number and final status of internal appeals, and the number of complaints received by the insurance department relating to the health plan or insurer and the number of "justified" complaints.**

This information should be reviewed and published in an annual report card allowing for comparison of certain components. The department should annually analyze data from past and current years to determine trends that have formed in any of these areas. The report card should include a statement indicating that the information contained in the report card is a snapshot of selected HMO operations. Consumers should be instructed to read their subscriber contract carefully to determine limitations and exclusions. Furthermore, consumers should be made aware that certain components cannot be used to compare health plans to each other but rather as indicators against previous reports to note areas of change, growth, and improvement within a health plan.

In all focus groups, testimony, and interviews held with providers, employers, and consumers, the committee repeatedly heard the same message -- more information is needed to make informed decisions about health care. Much information is already available through required filings at DOI, OHCA, or HEDIS reports, which health plans currently produce for employers.

The Department of Insurance must require that health plans file all information necessary to compile the report cards. The insurance commissioner should assign the staff necessary to compile any information that is not available through other existing sources. Health plans failing to submit the necessary information should be subject to a market conduct evaluation.

Market conduct evaluations should also examine enrollee participation in determining HMO policies. Connecticut law already requires enrollee representation on the boards of non-profit HMOs and for-profit health maintenance organizations must provide subscribers the opportunity to participate in matters of policy and operation. Compliance with this requirement provides another assurance that HMOs remain accountable to its members. The committee acknowledges that some

of the report card data such as per-member per-month fees do not relate to traditional health insurers. However, efforts should be made, whenever possible, to collect the other pertinent information from regular health insurers -- for example enrollment/disenrollment figures and grievance statistics.

As demonstrated by the private sector's own initiatives, information is the basis for a sound market driven health care system. Although there is general agreement that the compilation of information is critical, there are some concerns about the type of data that should be released. One concern is that consumers cannot understand the data. For example, health plans are concerned that utilization data are subject to misinterpretation and that consumers will believe that the higher the utilization, the better the health plan. Some disagree about the usefulness or reliability of the data itself especially self-reported information. Others question whether the release of imperfect data is fair to health plans, and if the release of the data would help ensure quality of care. The committee acknowledges that preparing accurate and usable information is difficult, however, compilation of existing data is an efficient and effective way of providing information to all interested parties.

In terms of utilization data, the department could examine both overall and specific utilization rates. For example, overall measures of utilization may include: the percentage of precertification requests approved; the rates of physician visits; and hospital stays for all enrollees. In addition, specific utilization measures may also be examined. The department could select a few procedures and compare each health plan's protocol standard to its actual utilization rate, similar to the committee's analysis of selected procedures contained in Chapter V. The release of this information should not be an indication of the "correct" level of service, but rather a comparative measure only. Consumers can reach their own conclusions about under service or over service -- especially when compared to fees. Because consumers may be overwhelmed with the amount and complexity of information they receive, the creation of a "report card" should allow for a user-friendly format.

Furthermore, the various components required by a report card prepared by the insurance department will benefit all parties. For example, basic descriptive information as well as enrollment figures used to compare health plans in terms of utilization and complaint activity will help employers and consumers. In addition, providers can use the report to compare plans in terms of medical management and utilization rates. Finally, health plans themselves may benefit from a report card comparison in that it will illustrate differences among plans and promote competition and quality improvement. The development of a "report card" has been adopted by one other state -- Minnesota, which is frequently cited as a leader in managed care regulation.

Information during open enrollment. The development of a "report card" compiled by the insurance department will provide consumers with basic comparative information on a wide variety of health plans. Of course, not all plans will be available to every individual. Just as important as broad comparative information to the consumer is a clear understanding of detailed benefits and exclusions and internal plan processes *before* a person signs on with a plan. It is too late to receive this important documentation after the consumer has enrolled. Currently, the provisions of an HMO health care agreement, contained in the evidence of coverage, are provided to the group contract

holder or individual contract holder as appropriate. Every subscriber must receive an evidence of coverage from the group contract holder or the health care center (C.G.S. § 38a-182). For consumers to make an informed decision, the committee believes this critical information must be made available for subscribers to examine prior to enrollment, and each receive a copy after enrolling.

Therefore, the program review committee recommends employers and/or health plans shall make the evidence of coverage available for review to consumers during the open enrollment period. In addition, the documentation must include a clear description of: benefits being covered or excluded and any changes from the previous contract.

The program review committee heard testimony from an employee who found out after signing with a plan that the coverage for a particular treatment had changed. This should not happen, and would be less likely to happen if this recommendation were implemented. Given the current judicial interpretation, the committee believes that self-funded plans could not be forced to comply with either the data submission mandates for the report card nor the full disclosure during open enrollment. However, as a matter of good faith, public relations, and building employee trust, the committee would hope that these ERISA governed plans would voluntarily comply.

Access to Care

The availability and accessibility of health care providers greatly affects members' ability to obtain appropriate health care. If a health plan lacks an adequate number of physicians, specialists, and institutional providers to serve its enrolled population, patient care may be compromised. Insufficient provider ratios increase the waiting time for members to receive care and the stress level of practitioners trying to meet the members' needs. Conversely, plans that have too many providers may over time gain an insupportable overhead cost as well as find it more difficult to control utilization of services. The following is a discussion of some alternatives for ensuring accessibility.

Mandated ratios. In a review of other states' approaches to adequate access to care, the committee found that 24 states require, through statute or regulation, that HMOs maintain a "sufficient ratio" or "sufficient number" of physicians to serve their enrolled populations. Nineteen of these states, however, fail to define what constitutes a minimum or adequate ratio. Five states (CA, DE, PA, NJ, and SD) require HMOs to maintain a specific minimum ratio of physicians to patients. However, California's provision allows plans that cannot attain the required ratios simply to demonstrate an "adequate" ratio.

In Connecticut, there is no mandate that enrolled populations be served by an adequate level of providers. However, all states, including Connecticut, *initially* review whether HMO applicants can adequately serve projected enrollee populations. Twenty-six states require HMOs to describe their physician/provider network in their applications for a certificate of authority to operate in the state. Sixteen of these states require HMOs to submit in their application a breakdown of the number and type of providers by speciality.

In Connecticut, all networks, including HMOs and preferred provider organizations, are required to annually file with the Office of Health Care Access (OHCA) information including the list of providers in the network and their geographic service areas. However, the filings are considered for informational purposes only because OHCA has no regulatory authority over these entities. As of March 1996, the information filed at OHCA indicated there are 67 different provider organizations. Due to its lack of enforcement authority, it is not clear whether the information compiled is complete and accurate. The filings usually consist of copies of the organization's provider directories listed by geographic area. While this seems to satisfy the statutory mandate, it can be misleading it terms of network size. Many times providers are listed more than once in directories because of their scope of practice. For example, a provider may be listed multiple times if he or she is considered both a primary care physician and specialist or if they have offices in various towns.

The committee believes managed care entities should continue to meet the OHCA statutory filing requirements. **However, to provide an accurate picture of the network, the committee recommends that the Office of Health Care Access filing requirement shall include a single count of: 1) primary care physicians; 2) speciality physicians; and 3) other contracting providers and facilities. In addition, the figures should indicate the number and percentage of each group's capacity to accept new patients. This information shall be provided to the Department of Insurance for incorporation into the annual report card. The Department of Insurance, in conjunction with OHCA, may verify this information when it develops the annual report. If the filing has not been submitted, the market conduct division within the insurance department should be notified. In addition, the Department of Insurance should note in the consumer report card that the health plan has not complied with the network information filing requirement.**

While provider staffing ratios are useful guides for health plan management to use when addressing recruiting needs, the committee concludes that mandating a specific minimum ratio is of limited value. Access depends on the capacity of contracting provider groups to serve members who have enrolled in their group. If providers join a number of different panels so they exceed their capacity to handle the patient load, access may still be compromised. Therefore, mandating specific provider ratios does not guarantee access.

"Any willing provider". A controversial issue related to access is "any willing provider" legislation mandating HMOs to contract with any provider who is willing to meet the HMOs' terms and conditions. Since 1994, three states (ID, KY, WY) prohibit a health plan from refusing to contract with any provider who will meet the health plans's terms and conditions. Minnesota's "any willing provider" legislation applies only to non-staff model HMOs with more than 50,000 enrollees and to non-physician providers. In 1984, Virginia required PPOs to allow providers the opportunity to apply and become preferred providers. Since then, three other states (GA, IN, TX) have added similar PPO mandates. Fourteen states' "any willing provider" statutes cover pharmacy services only.

Generally, HMOs oppose such laws, while provider groups favor them. HMOs argue that "any willing provider" legislation undermines their ability to keep costs down. Because "any willing provider" laws are relatively new, their impact on HMOs' ability to obtain financially advantageous contracts or on enrollees' choice of providers, is not yet clear. Moreover, "any willing provider" provisions do not address consumer concerns about potential access barriers within an HMO, like primary care referrals to specialists.

Point-of-service mandates. A few states have begun to address provider concerns about access and choice of providers by mandating HMOs offer point-of-service plans. Through a point-of-service plan, enrollees may obtain care outside the plan's network. However, point-of-service plans generally require higher premiums and large deductibles. In Connecticut, most HMOs already offer point-of-service plans. Nevertheless, mandating health plans offer a point-of-service plan does not mean employers must purchase it, or employees will use out of network providers if point-of-service plan is selected. The committee believes employers should not be mandated to purchase these products. Requiring employers to obtain this product is an unnecessary intrusion in the health care market potentially raising health benefit costs. Employers should be able to offer plans that are acceptable to employees but affordable. Further, self-funded plans would still be exempt from purchasing such plans. This would place an expensive mandate on the non-ERISA plans which are typically small businesses. For these reasons, the committee makes no recommendation that employers offer or purchase any particular product including point-of-service plans.

NCQA accreditation. Accessibility is also examined by one of the leading national accreditation organizations. The National Committee on Quality Assurance (NCQA) requires a managed care entity to establish its own standards for the availability of primary care providers and access (for example, establishing standards for access to routine, urgent, and emergency care; telephone appointments; and availability of member service lines). Most Connecticut HMOs either have or are in the process of obtaining NCQA accreditation. The committee believes health plans will voluntarily seek accreditation due to market demands and growing recognition of NCQA standards. The health plans that do not will likely face a competitive disadvantage.

HEDIS reports. Accessibility to care and services is one area of HEDIS reporting used by many health plans. A review of 1995 HEDIS measures indicates, as shown in Table IV-8, almost all Connecticut HMO enrollees are visiting their primary care physicians. In addition, HEDIS reports include two indicators that measure a health plan's network management -- physician turnover and board certification rates. Table IV-9 provides these rates as reported by Connecticut HMOs in their most recent HEDIS reports. Table IV-9 shows that approximately 80 to 90 percent of the HMO networks are board certified. Physician turnover rates, with a few exceptions, are relatively low. The committee believes that these measures are good indicators of an organization's medical management approach. **For these reasons, the program review committee recommends that health maintenance organizations should annually report provider turnover rates and percentage of providers that are board certified to the insurance department, which will incorporate the information into an annual report card made available to the public.**

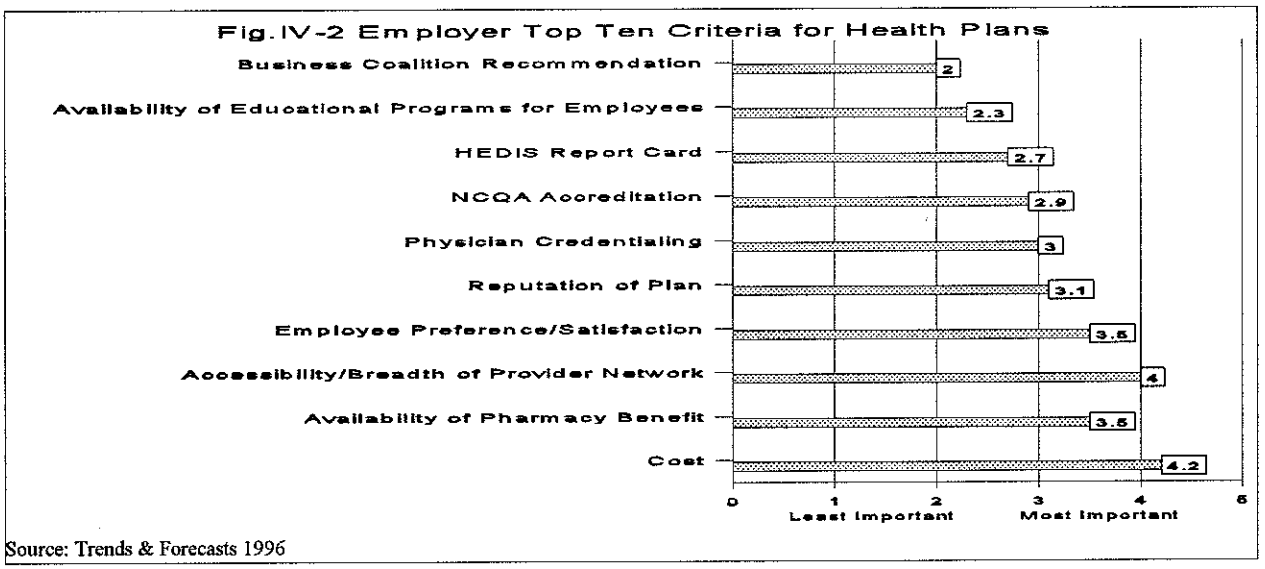
Table IV-8. HEDIS Access Indicator.		
HMO	Primary Care Physician Visits	
	Members aged 23-39	Members aged 40-64
Oxford	93%	89%
Kaiser	95%	95%
Cigna	94.06%	93.33%
PHS	94.1%	93.6%
BC/BS	92.47%	92.08%
USHealthcare	93.1%	92.4%
Aetna	96%	95%
Connecticare	95%	94.5%
MDHealth	NA	NA
Prudential	NA	NA
Suburban	NA	NA

Source: 1995 Health Plan HEDIS reports.

Table IV-9. HEDIS Medical Management Indicators.		
HMO	*Primary Care Physician Turnover*	*Primary Care Physician Board Certified*
Oxford	2.95%	94.5%
Kaiser	4%	92%
Cigna	8.5%	78.9%
PHS	3.4%	78%
BC/BS	2.5%	78%
USHealthcare	NA	NA
Aetna	5%	77%
Connecticare	1.5%	82.5%
MDHealth	2.8%	NA
Prudential	NA	NA
Suburban	NA	NA

Source: 1995 Health Plan HEDIS reports

Employer criteria for selecting health plans. Consumers often cite the relationship with their provider as one of the most important features influencing their satisfaction with health care and their decision to join or leave a health plan. To stay competitive, a health plan must be able to attract and maintain a panel of highly qualified providers. Connecticut employers who have met with the committee indicate that provider networks always rank high on their criteria used when selecting an employee health plan. This is supported nationally, as illustrated below, by the results of the 1996 *Trends & Forecasts* [8] national survey of employee benefit managers representing nearly 1.4 million covered lives. As shown in Figure IV-2, accessibility and breadth of the provider network is the second most important criterion used by employers when selecting an employee health plan. The most important employer criterion in choosing a health plan is cost.



Source: Trends & Forecasts 1996

Conclusions. One of the ways that health plans can control costs is to negotiate discounts with providers who are guaranteed that they will have the exclusive right to treat the plan's enrolled membership. Mandates such as "any willing provider" or options that allow enrollees to use any out of network providers severely limit a plan's ability to negotiate reasonable prices and contain costs. A plan's leverage in negotiating volume discounts with providers would be reduced because patients would be distributed across a greater number of providers. Furthermore, these mandates also eliminate a plan's ability to identify and exclude providers with questionable practice patterns and/or poor clinical outcomes.

The committee believes health care purchasers should be allowed to shop for health plans that are affordable for their needs. Employers have stated that, next to cost, the adequacy of the health

[8] *Trends & Forecasts* is a publication of CibaGeneva Pharmacy Benefit Report series that examines current and forecasted data regarding consumer, insurer, and employer perceptions concerning health care delivery and cost.

plan's network is most important in deciding which plan to join. To make these decisions, purchasers can refer to NCQA accreditation and HEDIS reports. Health plans will have to conform and follow suit in order to compete.

Furthermore, the committee believes health plans should be allowed to continue to freely select their panels. They should, however, provide accurate description about their networks to regulators and the public. The OHCA filing requirements, as amended by the committee recommendation, will provide the insurance department the necessary information to annually determine whether health plans have adequate networks. In addition, incorporating this information as part of a "report card" will allow purchasers/consumers to determine whether the number and percentage of network providers is sufficient to service its enrolled population.

Confidentiality

A fundamental principle of the provider/patient relationship is confidentiality. It is universally accepted that a patient must feel free to fully disclose information to the physician so the physician may most effectively provide needed services. In addition to the medical ethic code, the legal requirement that patient information be kept confidential arises from several sources. State medical practice acts and physician licensing statutes require physicians to preserve the confidentiality of patient records. Similarly, hospital operating statutes also establish confidentiality requirements. Federal and state laws also impose additional confidentiality requirements on psychiatric records, records of minors, and information regarding communicable diseases. Furthermore, there are state laws that prohibit the disclosure of personal and privileged information collected or received in connection with an insurance transaction.

Recent federal legislation. In late 1995, federal legislation was proposed regarding the privacy of medical records. The bill, referred to as the Medical Records Confidentiality Act of 1995, tried to ensure personal privacy with respect to medical records and health care related information. Although the bill initially received bipartisan support, it drew opposition from some patients' rights groups who believed the bill would not protect privacy but rather would allow for broad access by anyone employed by an organization receiving protected information. Other criticisms were that the bill would supersede state law and establish one loose standard of accessibility to patient records by allowing exceptions where the subjects consent is not required to release information. At the close of the Congressional session, the proposal was still pending in the labor committee.

The federal Health Insurance Portability and Accountability Act of 1996, known as the Kassenbaum-Kennedy bill, which did pass, also addresses confidentiality of medical records. The act requires the Health and Human Services secretary to submit recommendations to Congress with privacy standards within 12 months of the law's enactment date (August 21, 1996). The standards would establish rules for the collection and disclosure of confidential health information. The law further requires Congress to act on the privacy standards within three years, or if it fails to do that, the secretary of Health and Human Services may take action within 42 months. However, the law

will not supersede a provision in any state that imposes a more stringent requirement, standard, or implementation.

Access to medical records. In Connecticut, there are a number of laws relating to the handling of confidential records by state agencies such as the Departments of Public Health, Safety, Social Services, and Mental Health and Addiction Services. With certain exceptions,[9] Connecticut law ensures individuals access to their own medical records. State law also allows individuals to obtain their own personal information from insurers by written request (C.G.S. § 38a-982). Furthermore, insurers may not disclose personal information received in connection with an insurance transaction without the written authorization of the subject. However, insurers may release information to determine an individual's eligibility for benefits, payments, or to prevent fraud.

Access to mental health records. Federal and state law both address the confidentiality of mental health records. State law requires all communications and records relating to the patient/psychiatrist relationship be kept confidential. Disclosure is limited to a few specifically mandated situations (C.G.S.§ 52-146f). Connecticut law provides for certain safeguards on the release of psychiatric patient information by limiting the amount and type of information that can be required when a dispute arises over fees or claims. The statute (C.G.S. § 52-146f (3)) states that in cases where a dispute arises over the fees or claims or where additional information is needed to substantiate the fee or claim, the disclosure of further information shall be limited to the following: (a) that the person was in fact a patient, (b) the diagnosis; (c) the dates and duration of the treatment, and (d) a general description of the treatment, which includes evidence that a treatment plan exists and has been carried out and evidence to substantiate the necessity for admission and length of stay in a health care institution or facility.

Confidentiality issues. While health plans collect and create records containing information about individuals for a variety of reasons -- to determine eligibility, to track utilization trends, to identify indicators for preventive measures, the committee heard from provider focus groups and testimony at public hearings that there is a level of concern over the release of personal information. The issue of confidentiality was repeatedly mentioned by mental health and substance abuse providers as an area of concern. Providers contend that insurers are requesting more patient information than necessary and/or require confidential information be transmitted over phone or fax lines. Another confidentiality related concern is that patients fearing employers may discover their condition will either pay for services themselves despite available coverage or not seek services at all.

Although the general public does not have access to much of the personal information held by health plans, there is concern over the potential harm from release of information to employers. Specifically, breaches in the confidentiality of claims information and patient records that may hinder the ability of individuals to gain employment or obtain insurance. It has become more common now

[9] If it is determined disclosure of medical records would harm the patient's physical or mental health, health care providers may deny a patient access to his records (C.G.S.§ 20-7c).

for some large employers to require more information including utilization trends of their enrolled group as a requisite for offering a plan to their employees.

In discussions with health plans, the committee was told that one safeguard of confidentiality is to prevent disclosure of personal and identifying information and permit disclosure of information about persons if no connection can be made between the subject of the record and the information itself. The committee reviewed a number of HMO confidentiality provisions as detailed in their subscriber agreements as well as outlined in the provider contracts. Most HMOs also provided their internal staff policies that dictate confidentiality. *The committee found that most confidentiality provisions state that medical information about a member will not be disclosed without the member's written consent.* However, members usually sign a waiver when they enroll in a health plan that allows the plan to access information from the member's medical records for use by health plan staff and its affiliates to administer the contract, for use in bone fide medical research and education, for medical and financial auditing, and/or as otherwise authorized by law.

Providers interviewed by the committee expressed concern that health plans conducting quality assurance reviews seek to obtain more information than they believe is necessary for the purpose. Providers claim that health plans interpret contractual provisions relating to access to medical records very broadly. According to the providers, the health plans' interpretation of access would allow them to examine all of the provider's files. One example, cited by providers, was that when health plans conduct a file review of the provider's medical records as part of the recredentialing process they will examine medical records of patients who are not members of the health plan. Another example given by providers was health plans requesting parts of a member's medical records even if the member, or another party rather than the health plan, paid for the services.

Based on provider and consumer testimony, the committee believes there is a perceived threat to confidentiality in two areas: 1) broad interpretation of contractual access to provider records; and 2) disclosure of personal information to third parties such as employers.

With respect to contractual interpretations, the committee believes that when parties to a contract have a difference of opinion as to the interpretation of clauses, only a court of law can determine what the parties intended. As such, the committee does not make any conclusions about contractual provisions. However, the committee believes that confidentiality and privacy of patient records are an important part of any health care delivery system. This belief is supported by national accreditation organizations including the Utilization Review Accreditation Commission (URAC). URAC standards specifically address the information upon which utilization review is conducted. The standard specifies that utilization review organizations must collect only the information necessary to certify the admission, procedure, treatment, or length of stay. The standard stipulates that the utilization review company must not routinely request copies of medical records on all patient reviewed. If a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay, then only the pertinent sections of the records can be requested. Finally, the URAC confidentiality standard states that summary data shall not be considered

confidential, if they do not provide sufficient information to allow identification of individual patients.

Therefore, the program review committee recommends the Utilization Review Accreditation Commission standards relating to the access and handling of patient medical records be adopted through regulations promulgated by the insurance department before licensing a utilization review company. The regulations shall specifically indicate that health plans conducting quality assurance functions shall be limited to examining medical records of health plan members. The department, through its market conduct evaluations, shall be responsible for periodically verifying compliance.

Although all plans address the confidentiality of information in their contracts, to a certain extent variation exists both in contracts and in internal policies. The program review committee believes that as long as plans are complying with relevant federal and state laws, there does not have to be one set manner for HMOs to internally deal with confidential information. In addition, there will be federal regulations in this area pursuant to the 1996 legislation in the near future.

With respect to the second issue, the committee believes that health plans, including HMOs and utilization review companies or any party with which a health plan contracts, that have access to medical information, should be prohibited from giving or disclosing individual records to employers or any other party without the individual's consent. There is, however, no need for further state legislation since current Connecticut law prohibits the disclosure of personal and privileged information and has safeguards in place for any exceptions provided by law. It is important to note that these prohibitions are not absolute. Disclosure is allowed for certain auditing functions. Under federal and state law, self-insurers may be allowed disclosure of member information to perform necessary functions in connection with an insurance transaction involving the individual or to detect or prevent fraud, material misrepresentation, or criminal activity. In this capacity, employers requesting management audits of their health carriers may have access to employee utilization information.

The committee contacted the National Association of Insurance Commissioners (NAIC) to discuss the NAIC model act upon which existing Connecticut insurance privacy laws are based. According to NAIC staff, new guidelines are currently being developed to revise the present privacy laws, taking into consideration the changing health care insurance industry. Among the issues NAIC hopes to handle is accessibility of health care information by third parties. The committee believes the new federal regulations in conjunction with the revised NAIC guidelines will address the concerns expressed by providers and consumers. Meanwhile, judicial intervention is available to individuals who believe their privacy has been illegally disclosed.

Key Points

CHAPTER V : BENEFITS, UTILIZATION REVIEW, AND PROTOCOLS

➢ State law requires that, at a minimum, HMOs provide the benefits contained in the Federal Health Maintenance Organization Act as well as Connecticut's own statutorily mandated benefits. Most HMOs specifically exclude benefits that are not required but that is sanctioned by the federal HMO act.

➢ There are several deficiencies with utilization review and the way in which the current laws are implemented.

- Until July 1996, the insurance department had been collecting the $2,500 annual fee but had been doing little oversight of utilization review companies after the initial licensure.
- Because of the lack of dedicated staff to this oversight function, the utilization review companies have not fully complied with some statutory requirements, and the insurance department has not fully exercised it statutory authority in other areas.
- More information concerning utilization review companies is needed to adequately regulate them.
- Utilization review decisions that are made "pending" further review create confusion and ambiguity for providers and consumers about whether a procedure or treatment has been approved or not.
- Connecticut law is unclear in terms of what type of medical review it grants to patients or providers where a denial is upheld by the utilization review company on appeal.
- Utilization review companies must be responsible for their conduct in the market place including being accessible to consumers and providers.

➢ Staff analysis of protocols suggests:

- Use of pre-established standards are not universal among HMOs;
- There is variation between standard and practice;

Key Points

- Actual stays are typically longer than standards;
- Standards can lag behind practices;
- Standards are used as guidelines; and
- Outpatient mastectomies are not common but were performed prior to July 1, 1996 when the controversial protocol became effective.

➢ Input from local practicing physicians is necessary if protocols are to be accepted as workable, and adapted to Connecticut's health delivery system.

➢ Providers must be informed of guidelines and criteria under which they are expected to practice.

Chapter V

Benefits, Utilization Review, and Protocols

While there is a lot of variation in the types of HMOs, there is some similarity in the benefits offered in Connecticut and elsewhere. As discussed in Chapter III, to qualify for federal funds HMOs had to comply with the standards of the Federal Health Maintenance Organization Act, including offering basic benefits. The same federal act lists services that HMOs are not required to provide. Both the basic benefits and allowable exclusions are contained in Table V-1 on the following page.

Although most health maintenance organizations are currently not federally qualified, most benefit packages continue to meet those standard benefits requirements. In fact, Connecticut statutes governing health maintenance organizations require that, at a minimum, HMOs provide the benefits contained in the federal act, and they must also provide most of Connecticut's statutorily mandated benefits. The committee reviewed all approved health plan policies on file at the Connecticut Department of Insurance and found that most HMOs also specifically exclude the benefits that are not required. The committee file review found other services commonly excluded are: artificial hearts; transexual surgery; private duty nurse; services required by a third party including insurance, school, camp, employment, and court-ordered treatment; marriage counseling; and expenses related to a learning disability.

Often providers and consumers complain that certain benefits are not included in an HMO plan. *However, the committee found that, as Table V-1 indicates, many of the benefit exclusions are sanctioned by the Federal Health Maintenance Organization Act that authorized HMOs, and which established the framework under which HMOs operate.*

In addition to these basic benefits, HMOs' health plans in Connecticut must also offer a number of state-mandated benefits. These benefits are required of all licensed health insurers in the state, although there are minor differences between benefits required of HMOs and of other health insurers. As explained above, the insurance department reviews all health plans to ensure the policies offered include these benefits. Appendix B contains a list of all state-mandated benefits for HMOs and other health insurers.

Table V-1. Standard Benefits and Exclusions as Contained in the Federal HMO Act

Standard Benefits	*Standard Exclusions*
- physician services; - inpatient hospital services; - outpatient services (including diagnostic, treatment and X-ray); - short-term rehabilitation and physical therapy (2-month limit, as long as there is improvement); - substance abuse treatment; - medically necessary emergency services in & out of the service area; - 20 outpatient mental health visits as may be necessary and appropriate for short-term evaluation and crisis intervention; - laboratory and radiologic services in support of basic health services; - home health services; and - preventive health services including -- family planning, infertility services, eye and ear care for children, periodic health exams for adults, immunizations, and well-child care.	- corrective appliances and artificial aids; - mental health services, except as covered under basic benefits; - cosmetic surgery, unless medically necessary; - prescribed drugs and medicines, except as inpatient; - military service disabilities for which care is reasonably available; - ambulance services, unless medically necessary; - custodial care; -care for conditions that law requires treatment in a public facility; - regular vision and hearing exams; - experimental medical, surgical, or other health care procedures; - personal and comfort items including private rooms; - whole blood and blood plasma; - long-term physical therapy and rehabilitation; - durable medical equipment such as wheel chairs, respirators, etc. for home use

Source of data: Federal Health Maintenance Organization Act, as Revised October 1993.

Once a health plan's benefits have been approved, the plan may be marketed and sold. In contrast with health plans offered by regular health insurers, health plans offered by HMOs must provide each enrollee with evidence of coverage. This proof of coverage must not contain statements that are "unfair, inequitable, misleading, deceptive or which encourage misrepresentation." (C.G.S. § 38a-182) The proof of coverage must include several provisions in order to comply with statutory requirements. Those provisions must include:

- the name and address of the health care center (health maintenance organization);
- eligibility requirements;
- subscriber responsibility for co-payments, deductibles, and other out-of pocket expenses;
- list of services or benefits covered and period covered, and a detailed statement of services or benefits to be excepted, provided that at a minimum they conform to the federal HMO requirements;
- terms and conditions for canceling or terminating the agreement;
- claims procedures;

- procedure for filing a grievance;
- continuation and extension of benefits, and conversion of policy;
- description of service area, and out-of-area benefits and services;
- statement of amounts payable in fees and premiums by the subscriber and others on his/her behalf, and a statement of the payment grace period;
- statement describing any endorsements or attachments included in the agreement; and
- a statement that nothing attested to by the subscriber in the application can void the application or be used in any legal proceedings, unless there is a declaration of that as part of the application.

Utilization Review

Demand for health care grew out of control in the 1980s and early 1990s, and was spurred by two factors. First, patients want health services -- treatment and new technology -- that might help whatever illness or condition afflicts them. Coupled with consumer demand is physician motivation to do everything possible for the patient, either to more accurately diagnose the patient, or to treat a condition after a diagnosis is made. Physicians repeatedly confirmed this notion at focus groups and public hearings, stating they view their role as advocates for their patients. When consumers of health services and their physician advocates worked in tandem, they created a demand that was inexhaustive and resulted in annual double digit per-capita health care cost increases in Connecticut.

Employers, as the primary health insurance payors, demanded their insurance companies and health plans do more than just collect premiums and pay claims. Businesses demanded that health care services be better managed, and utilization of those services overseen. Managed care organizations and insurers responded by establishing a utilization review function. Utilization review staff employed by, or under contract with, insurers, health plans, or employers determine which services will be covered and in what setting. As a result, while benefits may be covered in a health plan, the enrollee is not necessarily entitled to receive them in all circumstances. The procedures in place to determine which services will be covered and in what setting -- called utilization review -- is a crucial facet of managed care.

Most hospitalizations and outpatient procedures need prior authorization from the health maintenance organization or its utilization review company. Utilization review also occurs for prescriptions. Companies known as pharmaceutical benefit managers monitor the kinds and amounts of drugs that physicians prescribe. Sometimes mental health benefits are also handled by a separate utilization review company that specializes in behavioral health.

Generally, the physician or the patient can call the utilization review company via an 800 number to determine if the procedure will be covered, and, if a hospitalization is involved, how many days will be preauthorized. Statutorily, the enrollee or the provider on record must be informed of the approval or denial within two days of obtaining material supporting the request.

If the decision is to deny, the decision must also include the reasons for denial, and outline the process for appeal, or the name and phone number of the person to contact regarding the appeal. Each utilization review company must have written appeal procedures that meet statutory guidelines including: an appeal decision be made by a physician within 30 days; if the case is an emergency or life threatening, that must be decided on within two days; and if the decision is to deny, the company should assure that a practitioner in the specialty related to the condition is reasonably available to review the case.

Licensure requirements. Since October 1, 1992, (via P.A. 91-305) Connecticut has regulated the companies that conduct utilization review functions. The statute requires the licensure of organizations "involved in the prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given or proposed for an individual." (C.G.S.§ 38a-226 to 38a-226(d)). Some of the regulatory components for utilization review have already been listed in the table comparing regulatory requirements contained in Chapter III, but a more thorough explanation of them is contained below.

A number of health maintenance organizations conduct their utilization review activities in-house, while others contract out for these services. In either case, the utilization review company or operation must be licensed. The insurance department annually licenses utilization review companies.

Prior to initial licensure, each utilization review company must submit documentation that demonstrates:

- it meets certain statutory criteria concerning notification, appeal, and clinical review procedures;
- health professionals making the utilization review decisions have current licenses or certifications from a state licensing agency in the U.S.;
- staff are available via toll-free telephone during normal business hours;
- no staff person receives compensation based on the number of denials made;
- practitioners in related specialties are reasonably available to review appeal cases not decided in patient's favor;

- it will abide by all applicable state and federal laws regarding confidentiality of records; and

- it allows a minimum of 24 hours for notification by enrollee after emergency care.

The law requires that hospitals allow utilization review company personnel on hospital premises to conduct their reviews, unless the hospital and the company have a signed contract to the contrary. The law also requires utilization review company personnel in hospitals to carry picture identification that clearly indicates their employer.

Once the companies have submitted the documentation prior to being licensed, they need to file only material changes with the insurance department within 30 days of the change. Annually, the companies are required to submit the name, address, and phone number of the contact person and the company, as well as its business hours, and submit a $2,500 annual licensing fee.

Licenses issued and fees collected. Table V-2 shows the number of utilization review licenses issued and the aggregate licensing fees collected each fiscal year, since licensing began in October 1992.

Table V-2. Number of Licenses Issued and Fees Collected by Year -- FY 93 - FY 96

Year	*Number of Companies*	*Licensing Fees Collected*
FY 93	78	$195,000
FY 94	101	$252,500
FY 95	119	$297,500
FY 96	129	$322,500
Total	129	$1,067,500

Source of data: Connecticut Department of Insurance

Filing requirements. *The program review committee found several deficiencies with utilization review regulation and the way in which the laws are implemented.* Until August 1996, the insurance department had been collecting the $2,500 annual fee but had been doing little oversight of utilization review companies after the initial licensure. The annual licensing fees, which were to be used for oversight of these companies only, had accumulated to slightly more than $1 million in the four years since licensure began. In August 1996, the insurance commissioner appointed two people to oversee utilization review activities and one person for general managed care issues.

Because of the lack of staff dedicated to this oversight function, the committee found that utilization review companies have not fully complied with some statutory requirements, and the insurance department has not fully exercised its statutory authority in other areas.

First, the insurance department needs to ensure that all businesses operating like utilization review organizations are licensed That identification responsibility becomes more difficult as more HMOs are "carving out" parts of their health care business. This means the HMO separates specific health services from the majority of the plan's business for purpose of compensation and utilization review. The HMO then subcontracts with other companies to oversee those specific health components.

Almost all of the nine HMOs that responded to the committee's request to provide information on "carve-outs" indicated that at least one part of the plan was separated, typically behavioral health or pharmacy. As carve-outs become more popular, the insurance department staff must oversee whether these companies are licensed for the functions they are performing. For example, if these carve-out companies are only paying claims, then licensure as a utilization review company is not necessary. However, if their responsibility extends to authorizing services, then those companies must be either licensed or accredited.

Second, the Department of Insurance needs to expand its initial filing requirements to require utilization review licensees to indicate which health plans they are serving. Further, utilization review companies need to provide more current information to the insurance department about organizational changes, staffing updates, and standards used for medical reviews.

Currently, the statute requires that any material changes be filed with the department within 30 days of the change. Only name, address, and phone number along with business hours must be updated annually. *However, a file review of 12 of the 129 utilization review companies, the program review committee found none of the files had updated information on company staffing, changes in protocols used, and the like since initial licensure of the company.* Companies need to comply with the material change notification, and the department needs to do a better job of verifying that no material changes have in fact occurred. The Department of Insurance recognizes the need for better information and has recently surveyed all licensed utilization review companies to assess their operations.

Utilization review data. In addition to organizational information, there is also a need for the utilization review companies to file actual utilization review statistics with the Department of Insurance. Currently, the statute gives the insurance department authority to require data relating to requests for services, denials, and appeals. However, until DOI recently surveyed all utilization review companies, the department had not utilized that authority. Thus, there currently is no one location where these utilization review statistics are kept in Connecticut.

Therefore, the Legislative Program Review and Investigations Committee recommends that annually each utilization review company must file with the insurance department:

- **any organizational or staffing changes that have occurred within the company since the date of the last filing;**
- **the names of all businesses, HMOs, or other entities that the utilization review company services in Connecticut;**
- **any health care services which the utilization review company or HMO has contracted out for servicing, and the name of the company servicing that part of the plan;**
- **any changes or revisions in protocols being used; and**
- **utilization review data including requests, approvals, denials, and appeals and their outcomes.**

Utilization Review Staffing

Physicians complained in program review focus groups that they and their office staff must deal with clerks when they are seeking an approval for a medical procedure or treatment. However, all of the 12 companies whose files the committee reviewed indicated they had health professionals on staff.

Further, while the statute does not currently require that health professionals make all utilization review decisions, it does require that "nurses, practitioners, and other licensed health professionals making utilization review decisions shall have current licenses from a state licensing agency or appropriate certification from a recognized accreditation agency in the United States" (C.G.S. § 38a-226c(6)).

Data obtained from the insurance department's recently conducted survey of utilization review companies, and displayed in Table V-3, indicate that most decision-making responsibility lies with health professionals and not clerks. While clerical staff are part of the utilization review operation, just as they are for almost any business, their decision-making ability is already limited via their own organizations. As the table shows, only four of the 23 clerks have approval authority and none can deny or negotiate the use of a treatment or procedure. In the other 19 companies, while clerks are the first contact, they only gather the information; the decisions are made by health professionals.

The program review committee believes that requiring all utilization review decisions to be made by health professionals would be imposing a staffing standard unnecessary for a great

percentage of the decisions that must be made in a review operation. Further, University of Connecticut consulting staff who issued the report on which the 1991 utilization review legislation law was based told the committee that it was not the intent of the legislation to restrict all review decisions to only health professionals.

Table V-3. Utilization Review (UR) Staff and Decision-Making N=103

Contact with UR Company	*Decision Making Responsibility Given to Staff*
Number of Companies Where Clerk is First Contact = 23 (N=23 Companies)	Number of Companies Where Those Clerks Have Authority To: Approve=4 Deny=0 Negotiate=0 (N=23 Companies)
Number of Companies Where Nurse is First Contact =56 (N=56 Companies)	Number of Companies Where Nurses Have Authority To: Approve=56 Deny=19 Negotiate=46 (N=56 Companies)
Number of Companies Where Other Staff are First Contact = 24 (e.g. case manager) (N=24 Companies)	N/A

Source of data: Department of Insurance Survey of Utilization Review Companies

However, to eliminate statutory confusion and give greater assurances to the practicing medical community regarding who performs utilization review functions at what level, **the program review committee recommends that any utilization review decision to initially deny services be made by a health professional.** This would allow staff who are not health professionals to approve routine certification requests. These approvals can be done over the phone with a minimum exchange of information. If the request cannot be approved based on the information given, or if it appears the request should be denied, then that request should be handled by a health professional. Further, according to the data in the table, authorization for denials (and most approvals) is only given to medically trained personnel. Therefore, this recommendation would not require utilization review companies or HMO internal review operations to incur additional administrative expenses for hiring additional or replacement staff.

Whatever the level of staff making the utilization review decisions, it is crucial that they are all well-trained -- able to gather data on requests, have a basic understanding of the medical standards being used to make decisions, and relay the decision to the requesting party. Even if the staff are health professionals, utilization review is different than actively delivering health care, and utilization

review staff persons need instruction and preparation. **The program review committee recommends that utilization review companies shall submit information on their staff training as part of the annual filing report to the insurance department.** The committee does not recommend any set number of hours of training for utilization review staff.

Utilization review decisions. By statute, utilization review companies must notify the patient or provider within two days of receiving all information upon which a decision can be made. However, in the committee's review of complaint files, it is apparent that often cases involve complicating factors, further information is required, and decisions take longer and are not as well-communicated as they might be. In some cases, health plans make preauthorization approvals "pending" a more complete review of all the pertinent medical records, and then deny just prior to the scheduled treatment or procedure. In other cases, companies deny the claim after the enrollee had the procedure or treatment. The patient in these cases believed the procedure had been approved, when the utilization review company indicated that it had not.

The committee believes that most of these cases could have been averted with a clearer exchange of information. Recognizing that communication is crucial to effectively execute managed care, **the Legislative Program Review and Investigations Committee recommends the following:**

(1) Utilization review companies shall make and communicate a utilization review decision, only if all the required documentation to make that decision has been received. Approvals "pending" receipt of all the information shall be prohibited.

(2) If additional medical documentation is necessary before a decision can be made, the utilization review company shall clearly indicate to the physician or patient what information is still needed. (The statute already requires that the provider of record is responsible for providing all relevant information necessary to make a decision, and failure to submit the documentation may be grounds for denial of the service.)

(3) Utilization review companies shall communicate the decision to patients within 48 hours of having received all the medical documentation, as currently required by statute. Patients must be given written confirmation of an approval and a confirmation number until a written authorization is received.

If these procedures are followed, they should significantly lessen any ambiguity about whether a procedure has been approved or not. It would give the consumer or the physician a verification confirmation number or written authorization that would serve as a guarantee that the treatment was approved. Eliminating "pending" decisions should also reduce confusion about whether an approval was actually granted. Consumers or providers who believe these processes are not being followed may report potential violators to the insurance department for further action.

Appeals Decisions and "Medical Necessity"

When consumers are denied a health care service, they often will not agree with the decision. When the decision deals with whether a particular benefit is covered or excluded, a review of the subscriber contract usually provides a clear answer. That document spells out in great detail which benefits are provided and which are not. When the decision is based on whether the service is medically necessary or not, the result is not always clear cut. Each subscriber enrollment agreement contains a plan's definition of "medical necessity". A typical definition states:

> health services that are required for illness or injury. Physician determines the medical care, but coverage is subject to medical necessity as determined by XHMO. Health services that are not medically necessary shall not be covered health services under the agreement.

Of course, disagreement over medical necessity can arise between the health plan and the treating physician. The committee believes the method by which those conflicts are resolved is currently deficient, because the statutes are unclear, and because they do not provide the consumer with sufficient procedural redress if disagreement occurs.

State statutes governing utilization review currently include a requirement that companies establish a written appeals process, including those appeals involving medical necessity. The company must inform the patient or provider of their right to appeal when any medical service is denied. Appeal decisions must be made as soon as practical, but no later than 30 days after the appeal is received. Statutorily, on appeal all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed medical practitioner, which is usually the medical director of the HMO or utilization review company.

The statutes also state that "in cases where an appeal to reverse a determination not to certify is unsuccessful, each utilization review company should ensure that a practitioner in a specialty related to the condition is reasonably available to review the case" (C.G.S. § 38a-226c (7)). *The program review committee found this statutory section is unclear in terms of what type of medical review it grants to patients or providers where a denial is upheld by the utilization review company on appeal.*

To ensure that consumers have a guaranteed opportunity for review outside of the health plan on issues of *medical necessity*, **the program review committee recommends that Section 38a-226c of C.G.S. be modified to specify that:**

In certain appeals that have been denied, the utilization review company shall have the case reviewed by an *actively practicing Connecticut specialist* in the field related to the medical condition that is the subject of the appeal.

This specialist review shall be granted in cases where an appeal to reverse a determination not to certify has been unsuccessful, and the reason for the denial is based on *medical necessity*, including whether a treatment is *experimental or investigational.*

The utilization review company shall be financially responsible for the review, and shall obtain the review within 30 days of the denied appeal. The actively practicing physician's decision shall be final. Documentation of the review, the name of the physician who performed it, and the decision will be kept at the utilization review company so that insurance department staff may verify the process was followed.

The committee believes this recommendation recognizes there is no one definition of "medical necessity", nor can one be legislated. The determination of medical necessity will vary depending on the case and the patient, and will change as medical advances are achieved. Thus, a practicing physician in Connecticut should make that decision based on the specific circumstances and his/her medical judgement. Committee members believe this recommendation is the best option for reviewing denials involving medical necessity.

The recommendation guarantees that a final review of a denial based on medical necessity is done by a physician who is not the medical director of the HMO or utilization review company. Medical directors must ensure that medical decisions are applied uniformly among all enrollees, but some critics charge they deny health care to increase company profits. At the same time, the recommendation also removes the final decision of conflicting medical opinion from the treating physician, whose objectivity is also in question since he or she is advocating on behalf of the patient.

This recommendation places the decision to resolve conflicting medical opinions in the hands of a qualified third party. Consulting fees for the medical review of the denied appeal will be paid by the utilization review company or the HMO. The program review committee concludes that a certain level of trust must be placed in the physician community in Connecticut to serve as objective medical consultants, regardless of payment source.

The recommendation does not call for review responsibility by a governmental agency or an agency on contract to conduct medical necessity reviews for a number of reasons. The program review committee considered assigning responsibility to the Connecticut Peer Review Organization (CPRO), which handles all utilization review functions for Medicare in Connecticut. However, CPRO told the committee that it also contracts out to one or more specialists when an issue of medical necessity arises. Further, the committee considers the responsibility of handling utilization review for a government-sponsored and largely tax-supported system with a set benefits package significantly different from reviewing decisions on dozens of different employer-paid plans, and thus does not consider CPRO an appropriate option.

Likewise, the program review committee believes a state governmental agency would be ill-

suited to staffing such a function with specialty physicians, while selecting and contracting with such physicians on each case would be too time-consuming and costly. Further, health care is not a state-mandated program like unemployment compensation or workers' compensation where the state has an adjudicatory function to ensure eligible persons are receiving their government-entitled benefits. Health care is still a benefit purchased largely by employers in the marketplace. State government should ensure that health plans have consumer protection features, and that those processes and procedures are followed. It should not create an alternative medical appeals mechanism.

Finally, the recommendation clearly limits the outside specialist review to questions of medical necessity, including whether treatments are investigational or experimental. It would involve questions of medical interpretation only, and not legal questions of denials that are limited because of benefits clearly excluded by contract.

Market Conduct of Utilization Review Companies

In addition to reporting requirements to the insurance department, utilization review companies must be responsible for their conduct in the market place including being accessible to consumers and providers, as well as meeting the statutory process for making health services utilization decisions in the statutorily prescribed timeframe.

Access to utilization review companies. Control of utilization of medical services is a key platform upon which managed care is based. But managing those health resources must be done through an appropriate process -- by receiving requests, reviewing the request using written standards, and communicating those decisions in a timely fashion. To do that, utilization review companies must be accessible.

One statutory requirement of utilization review companies is to have a toll free "800" number available at least 40 hours per week. Physicians and other providers have complained utilization review operations are not accessible, providers get taped messages, reviewers do not return calls or written requests, and review companies do not make decisions in a timely fashion.

To ensure that utilization companies are accessible and responsive to consumers and providers, **the program review committee recommends the Division of Consumer Affairs within the Department of Insurance be notified if utilization companies are continually inaccessible, if they lose materials or documents sent to them, or if they fail to make or communicate decisions in a timely fashion. These complaints should be coded and tracked, and reviewed by department staff assigned to utilization review functions. Companies whose market practices in this area appear to indicate a problem should be targeted for further attention, either by the Market Conduct Division or utilization review staff, and if violations of the statute are occurring, companies could be penalized, after a hearing, as already outlined in C.G.S. § 38a-226b (1) through (4).**

C.G.S.§ 38a-15 allows the expense of any market conduct examination be paid for by the company being examined. Therefore, the committee does not anticipate financial or staffing resources at DOI should be an obstacle in carrying out these market conduct responsibilities.

Protocols

The standards used by the utilization review companies to approve or deny a procedure are known by a number of different terms -- e.g., protocols, clinical criteria, practice standards, or practice guidelines. These standards have been and continue to be developed by a wide variety of organizations inside and outside of government. A recent GAO study on the development and use of these practice guidelines stated that about 75 organizations had developed 2,000 guidelines over the years. Federal agencies like the National Institutes of Health and the Centers for Disease Control have a strong involvement in this area as do physician organizations like the American Medical Association and the American Academy of Pediatrics. Other guidelines have been developed by for-profit companies like Milliman and Robertson (M&R), an insurance actuarial firm based in Seattle and Interqual, a medical review specialty company located in Marlborough, Massachusetts. Both develop and market packaged standards to health care organizations.

While there are no requirements for what protocols must include, how they are used, or availability to providers, Connecticut statutes do require that each utilization review company list its protocols with the insurance department prior to being licensed. The law also requires the protocols be written, periodically evaluated, and updated with appropriate involvement from practitioners. According to insurance department records, and the HMO responses to the committee requests for protocol information, Connecticut HMOs are using a variety of protocols. Ten different nationally developed criteria are used -- the most common are Interqual and Milliman and Robertson -- and a number also use internally developed standards.

Managed care organizations may adapt prepared standards to meet their needs. The GAO study[10] stated that most of the 19 health plans in their review did not use the guidelines off the shelf, but modified them for a number of reasons. For example, physicians are more likely to accept the guidelines if they have been adapted to local practices. Other justifications for changing practice guidelines are: to better fit the health care delivery system of a certain area; to promote a more cost-effective approach to treating an illness; or to simplify complex procedures that might include complicated formulas or algorithms. Most HMOs indicated in their response to the program review committee's request for information on standards that protocols are used as guidelines only and treating physicians set the length of stay, or that a concurrent review conducted by utilization review nurses of patients in hospital takes place daily, and that is what determines length of stay, not the standard.

[10] Practice Guidelines: Managed Care Plans Customize Guidelines to Meet Local Interests, General Accounting Office, May 1996.

Protocols also exist for prescription drugs. Managed care organizations develop drug formularies -- a list of prescription drugs approved for use by that health plan -- that are dispensed to patients by participating pharmacies. These formularies may be developed either because the listed drugs have proven benefits over other similar drugs, or because the health plan has a contract with a pharmaceutical company or companies to purchase the drugs on the formulary at a discounted price.

Use of protocols. Physicians have claimed they are not informed about what the protocols are, that they are "cookbook medicine" prescribing how they should practice medicine, and that some of the recovery standards are unrealistic. Many cite Milliman and Robertson standards as an example.

In addition to the controversy over the protocols themselves, there is disagreement about how they are implemented. Physicians in staff focus groups indicated that they had to make repeated calls and sometimes "fight" with an HMO or utilization review company to obtain approval for a procedure that might not be indicated in the protocols. However, in phone interviews the committee staff conducted with staff of Milliman and Robertson and Interqual, both insisted the protocols are guidelines, and not hard and fast rules.

Milliman and Robertson sent written clarification of its protocols termed "optimal recovery guidelines", stating the "guidelines define what clinical progress the patient will have if they do as well as one expects without complications, and what clinical care should be provided to help that patient achieve that level of recovery. Therefore, each diagnosis has an assigned goal length-of-stay for each admission." M&R states in its experience approximately 80 percent of patients under the age of 65, and 40 to 50 percent of Medicare (over age 65) patients should be able to meet the standard. However, M&R further cautions that, in order to achieve optimal recovery and meet their length-of-stay goals, a health care delivery system must provide adequate alternative treatment settings to hospitals.

In evaluating the protocols and their use, the program review committee selected eight procedures and asked Connecticut HMOs to provide the standards each used during 1995 for precertifying a length of stay for that procedure.[11] They were also asked to provide actual utilization statistics on the range of stays, and the average and median length of stay for each of the procedures for the same year.

Several shortcomings with the data need to be noted. First, not all HMOs responded though the committee made repeated attempts to obtain the data. Second, not all HMOs that responded provided all information. For example, not all supplied median length of stay, thus the program review committee used average length of stay (LOS) in its analysis to capture as many elements as possible. Third, because HMOs capture their utilization data using different codes, it's likely some utilization statistics of the procedures were missed because of coding variations. Fourth, because of this coding problem or due to actual low utilization of some procedures, the average LOS may be based on very low numbers (5 or 6 cases). However, noting their limitations, the data do give some

[11] The procedures selected were vaginal delivery, cesarean section, single total hip replacement, lumpectomy, mastectomy, removal of ruptured disk, double bypass heart surgery, and abdominal hysterectomy.

indication of what is happening with medical standards and actual utilization in Connecticut.

The committee took three of the seven selected procedures and developed two timelines. The top one in each case provides the HMO's estimated or standard length of stay, while the second one provides the timeline showing what the average length of stay was using the HMO's actual utilization data. The results are depicted in Table V-4.

Based on the data reported in Table V-4, the program review committee found that:

- *use of pre-established standards is not universal among HMOs* -- Physicians Health Services, Kaiser, and Oxford all indicated that they had no pre-established standards on length of stay for these procedures;

- *variation exists between standard and practice* -- almost without exception, the HMO's average length of stay varies from the standard or protocol;

- *actual stays are typically longer than standards* -- for all three procedures, most HMOs had average length of stays longer than their standards;

- *standards can lag behind practices* -- Connecticare had longer pre-established stays than the actual average length of stay for all three procedures. Comittee inquired about this and was told that Connecticare had been using Interqual standards in 1995, which were lagging behind actual medical practices. Connecticare has since switched to Milliman and Robertson standards; *standards used as guidelines* -- the differences between the standard and the actual average length of stay indicate the protocols are being used as guidelines; and

- *outpatient mastectomies are not common but were performed prior to adoption of a new, controversial protocol* -- based on the data filed and the codes used, HMOs indicated that only five mastectomies were performed on an outpatient basis during 1995. These outpatient mastectomies would have preceded the adoption of new M&R protocols in July 1996, indicating these were physician/patient decisions.

One of the results of managed care and its use of protocols and utilization review methods has been the continuing drop in hospital stays. As cited in Chapter I, the average length of hospital stay declined from 6.3 days in 1993 to 5.5 days in 1995 -- a drop of almost 15 percent in two years. Data analysis performed by the Connecticut Hospital Association, at the committee's request, on length of stay and readmission rates for the same selected procedures confirms that length of stay for the procedures has indeed decreased from October 1992 through March 1996, and the data show no clear evidence that readmission rates following discharge have risen. The report indicates that the actual numbers of patients readmitted are small, and that no clear trends on readmission rates can be

Table V-4. Comparison of Standards Used and Actual Utilization Data for Length of Stay for Three Selected Procedures

Mastectomy

Standard Length of Stay: Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5

Cigna
NYLCare***
MD*
Aetna*
Connecticare
Blue Cross*
Aetna*
MD*

Actual Average Length of Stay: Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5

Kaiser*
Blue Cross*
MD*
Aetna*
PHS* Blue Cross*
Connecticare**
MD*
Cigna**
PHS Oxford Aetna
Kaiser*

Removal of Ruptured Disk

Standard Length of Stay: Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5

Aetna
MD
NYLCare
Cigna
Connecticare
<Blue Cross

Actual Average Length of Stay: Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5

Aetna
Cigna
Blue Cross
Oxford
Connecticare
Kaiser
PHS
MD

Abdominal Hysterectomy

Standard Length of Stay: Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5 6

NYLCare
MD
Blue Cross
Cigna
Aetna
Connecticare

Actual Average Length of Stay:Days

0 .5 1 1.5 2 2.5 3 3.5 4 4.5 5

MD
Cigna
Connecticare
Oxford
PHS
Aetna
Kaiser
Blue Cross

*** NYLCare is listed only under standard LOS because it was only licensed in 1996 and has no utilization data
* LOS Standard depends on Code: Mastectomy ,Mastectomy with Reconstruction, or Radical Mastectomy. (**Also, Cigna reported 3 of 31 mastectomies done on outpatient basis, while Connecticare reported 2 of 35 mastectomies were done on outpatient basis in 1995)
< Blue Cross is decreasing its standard for this procedure in late 1996

Source: LPR&IC Staff Analysis of HMO Responses on Protocols and Utilization

identified.[12]

The program review committee believes that requiring a minimum length of stay for any procedure could obstruct progress at further reducing length of stay under sound medical practices, and is an unnecessary intrusion into the area of medicine. Establishing standards in law does not allow for the advancement of medical technology that makes a certain surgery outdated, or a hospital recovery period unnecessary.

Further, the committee concludes that protocols are being used largely as guidelines, and therefore makes no recommendation that certain protocols be used nor that others should be banned. Finally, Connecticut recently witnessed what can occur when protocols don't match with public expectations.[13] The program review committee believes that, when the media, the medical community, and the public react negatively to an HMO practice (even a guideline), the HMO will change it. Good public relations matter to HMOs, as with any enterprise, but the committee believes it is better that the public and the marketplace demand it and not have the legislature set it.

While the program review committee does not recommend legislative adoption of any standard, nor prohibiting a particular protocol, that does not mean that the way protocols are developed and implemented does not need corrective action. The recommendations adopted by the committee for improving these processes are contained below.

Local input to protocols. The purpose of protocols is to bring more uniformity to the practice of medicine, as well as to control costs. However, two important factors concerning protocols were repeatedly noted during the course of this study. First, input from local practicing physicians is necessary if protocols are to be accepted as workable. Second, there must be a recognition that delivery systems vary in different areas of the country. Even protocol developers recognize that optimal recovery goals assume a certain delivery structure. Local practicing physicians have an appreciation for the state or region's health care delivery system, and recognize aspects of the state's health care delivery system that differ from those where protocols are developed. For example, California may have greater access to sub-acute care than Connecticut and that must be acknowledged in implementing protocols.

Local input does not mean physicians should serve as obstacles to medical progress or impede legitimate reduction in hospital stays and changes in treatment settings. It does mean that health plans ought to consider reasonable local concerns and delivery constraints raised by physicians before implementing standards, especially those developed in other areas of the country.

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[12] Readmissions Study prepared for the Legislative Program Review and Investigations Committee by the Connecticut Health Information Management Exchange (of the Connecticut Hospital Association) January 1997, and Mastectomy Procedure Readmission Data Report prepared by the same organization, December 1996.

[13] The protocol concerning outpatient mastectomy received much negative publicity in the media, and prompted one HMO to reconsider the use of the protocol

Currently, the Connecticut statutes require that plans "utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners." However, as currently written, the laws allow those practitioners to be located in another area of the country. And, while it may be assumed the statute means actively practicing physicians, it does not clearly say that. The program review committee believes this requirement does not ensure adequate input from actively practicing physicians in the immediate geographic area.

A recent GAO study on practice guidelines states when published guidelines differ from a plan's clinical and financial objectives, they are typically customized with the active participation of network physicians, and local adaptation may be necessary when the standards are too complex or inconsistent with local practice. Further, courts have held medical plans whose standards significantly differ from the community are acting in bad faith and can increase the likelihood of liability for bad medical outcomes. Finally, if a protocol was so contrary to local practice that physicians were continuously being granted exceptions, it would appear to be more cost-effective and administratively efficient to change the standard.

For all these reasons, the Legislative Program Review and Investigations Committee recommends that the statute be modified to require that, prior to implementing new or revised medical protocols or utilization review procedures, health plans shall obtain input from physicians actively practicing in Connecticut. Such input should be obtained from a number of providers in a variety of medical specialty areas, and should be documented so it can be verified by the insurance department. Input from the medical community objecting to new or revised standards could not prevent a health plan from implementing such protocols, but the health plan would have to document why practitioner objections were not warranted, or how the original standards were changed to accommodate objections.

Health maintenance organizations assured comittee during this review that local physician input was always sought, a position not substantiated by physician groups. This recommendation would ensure physicians their input is important to the protocol implementation process, but would not allow physicians the power to approve or deny the protocols before their implementation.

Instead, the recommendation would allow the insurance department to use the documented input as it deemed appropriate. If a health plan implemented protocols despite continued physician protests, the Department of Insurance might report that as part of a consumer education tool. On the other hand, if a health plan did not use revised or updated protocols, the insurance department could note that in the report card.

Access to protocols. Even after protocols are developed and being implemented, opinions differ on how informed physicians and other practitioners are about protocols. Physicians claim they are kept in the dark about protocols because HMOs fear doctors will be able to have more treatments approved if they know what the standards are. HMOs claim they welcome physician input to the development and revision of standards and the plans make every effort to inform and educate physicians about standards and revisions.

Regardless of their involvement in the development prior to implementation, physicians must be informed of the guidelines and criteria under which they are expected to practice. Committee members recognize the standards can be voluminous, or computerized, and that health plans cannot be responsible for making copies of every guideline available to every practicing network physician. On the other hand, if a physician wishes to examine the standards or guidelines, the committee believes the health plan has a responsibility to accommodate the provider. Further, the committee concludes that when a denial of service is because the services runs contrary to an established protocol, the physician must be furnished with a copy of the protocol.

Therefore, the Legislative Program Review and Investigations Committee recommends that upon the request of a network provider, each plan make its protocols -- those standards upon which decisions to approve or deny a service -- available for that provider's examination at a location and time determined by the health plan. Further, when a health plan denies a treatment because the treatment, procedure, or service is in conflict with a protocol, the physician shall be furnished a copy of the protocol, with any supporting criteria, and an explanation of why the request did not meet the protocol.

Disclosure of protocols under which physicians are expected to practice is only reasonable. These standards are developed to help change practice patterns, eliminate bad practices, and promote uniformity. If doctors are expected to conform to these guidelines, they at least have to know what they are. HMOs have to trust physicians in their network to use the criteria to practice good medicine in an informed way and not to "game" the system to have more treatments approved. Further, the utilization review laws in Connecticut currently establish prohibitions and penalties against providers or enrollees who furnish misleading or fraudulent utilization review information. If a health plan or utilization review company finds it is not being given truthful information by a provider, it should inform the commissioner of insurance so the department can determine whether a violation has occurred and, if so, assess a civil penalty against the violator.

CHAPTER VI : PROVIDER CREDENTIALING AND CONTRACTING

- HMOs must balance the need to have broad enough networks to satisfy consumer and employer demand with the need to select high quality providers who will provide good health care at reasonable costs.
    - After cost, the most important criteria used by employers when selecting an employee health plan are accessibility and breadth of the provider network. Health care purchasers should be allowed to shop for health plans that are affordable and meet their needs.
- Few physicians have been "deselected" or failed to have their credentials reapproved.
- HMOs' "profiling" of providers brings added provider accountability to the health care system that was lacking prior to managed care. However, these "profiles" should not build in a disincentive to caring for sicker patients or those who suffer with chronic conditions.
- Contract clauses which impose limits on physicians discussing treatment options, or clauses that could appear to impose such a prohibition, should be prohibited.
- Health plans and providers should be allowed to contractually agree on the amount and method of compensation. However, the method of compensation should be disclosed to the public.
- Indemnification clauses are only restrictive to the signing parties and do not prevent or prohibit consumers from seeking legal remedies from the parties independently.
- Most health plans carry professional liability insurance.
- Health plans should give notice of termination to providers and consumers.

Chapter VI

Provider Credential Review and Contracting

Two major concerns of providers are HMO physician selection methods and criteria and the language in the contracts they sign in order to be in the managed care networks.

Credential Review and Profiling

Initial selection. Managed care organizations have the authority to select the providers for their networks. Connecticut does not have "any willing provider" legislation (i.e., any provider who meets the educational and professional criteria must be included in the network). Forty-six states allow managed care plans to select their own physician networks.

Interest in joining a network can come from the health maintenance organization or the physician or group of physicians. Generally, an HMO might be looking to start or expand a provider network in a geographic area, or expand the number of providers it has in a given medical specialty, as enrollment increases.

All health maintenance organizations require that each physician who wishes to become part of the network submit an application. Typically, as part of that application the provider signs a consent form to have confidential information released from various regulatory agencies, including the state's licensing agency, regarding disciplinary actions.

Also, as part of the application process, the physician agrees to abide by the operating guidelines of the HMO or other managed care organization, including allowing a review of office procedures and medical files maintained by the physician's practice. Physicians must also agree to cooperate with the health plan's quality management program including periodic review of the physician's practice statistics compared with physician peers in the network.

Credentials. There are some variations in what managed care organizations require but all mandate unrestricted licensure and admitting privileges with at least one participating hospital, an adequate level of malpractice insurance, and assurances of 24-hour coverage. Table VI-1 presents a typical example of selection criteria used, and how they are typically verified.

Table VI-1. Example of Selection Criteria for Physician Providers

Requirement	*Verification Method*
Current unrestricted license in state	1) state licensing agency; 2) admitting facility w/date of last verification
1) Admitting privileges at participating hospitals; or 2) non-participating hospital if more than 30 miles away; 3) at least half of MDs of large practice must have admitting privileges at participating hospitals	Primary verification from facility -- date of appt; scope of privileges
Current unrestricted Drug Enforcement Authority (DEA) Chemical Dispensing System (CDS) certificate if appropriate	Copy of Certificate
24-hour day coverage	Signed Application
Graduation from Medical or Osteopathic School	1) School Verification; 2) State Licensing Agency 3)American Board of Medical Specialties compendium
Current malpractice Insurance $1 million general liability $3 million professional liability	original certificate of coverage w/30 day cancellation preferred; 10 day required
Completed application form including: 1) work history; 2) professional liability claims history; and 3) history of loss, limitation, suspension, denial, or voluntary relinquishment of privileges	Signed application Verify with: National Practitioners Databank (NPDB); Institutions
History of Revocation of DEA # History of Sanction Activity by Medicare or Medicaid over last 3 years Check of Felony Convictions	Verification w/ DEA Verification from Federation of State Medical Boards, Health Care Financing Administration and State Medicaid officials; NPDB
No physical or mental impairment that impedes ability to carry out duties; no chemical dependency or substance abuse for last 5 years as attested to on application	Signed application
Current report from NPDB	NPDB
Current Report from State Board of Medical Examiners or Dept.	Verification w/Board or Department
Favorable review of office visit and review of 3 medical records	Written documentation of results
Favorable result (credential review) of member complaints; Quality Assurance or Quality Improvement reviews, utilization management, and member satisfaction surveys	Evidence that these data have been reviewed

Source of data: Sample of Credential Criteria Filed With Insurance Department

The verification of physician credentials can be done by the HMO itself, or can be contracted out to groups or companies that specialize in the business. Most managed care organizations review credentials of physicians in their network every two years. Once the verification of credentials is complete and approved by the HMO, a contract is signed between the HMO and the doctor, or group of doctors. Connecticut law requires that this contract be in writing and the insurance department review a sample of the contract language prior to HMO licensure. The statutes also require that the selection criteria be submitted to the Office of Health Care Access annually. Thus, all providers wishing to know what the criteria are can readily obtain a copy.

However, providers have concerns about selection criteria that go beyond information and access to them. Providers worry they are not being selected for panels because HMOs already have sufficient providers in a geographic area or in a medical specialty area. HMOs readily admit this type of selection occurs, and may close the panel to new providers when they believe they have an adequate number.

The program review committee believes HMOs should be allowed to continue selecting their panels in this way, just as any other business may choose its independent contractors. The credential review criteria, and whether a provider meets them or not, is a contractual matter between the managed care organization and the individual or group of physicians.

As indicated in Chapter II, most HMOs have continued to expand their panels significantly, and the Connecticut doctor-to-patient ratio surpassed any established ratio standards in the few other states that have them. Selection criteria also provide consumers with some confidence the physicians in the network have met some additional screening beyond state licensure. For example, selection criteria often require that physicians be board-certified, which means they have passed an examination by a specialty board and are certified as a specialist in that medical area.

Since Connecticut does not have a law requiring that any willing provider be allowed to join a network, not all networks include all physicians. On the other hand, a physician can be on more than one network. In Connecticut, there are no requirements that the plans have a certain number of physicians (either total number or ratio to members), and the plans are not reviewed for that criteria. However, each managed care organization is required to annually file its network listing by specialty, with the Office of Health Care Access, but the office has no approval authority. Typically, an enrollee receives a list of the doctors' names in the network, although there is no statutory requirement that this be provided.

HMO networks. Table VI-2 provides a snapshot of the HMO networks in 1990 and again in 1994. As the table shows, all of the HMOs have added substantially to the number of physicians in their networks. (The number includes primary care physicians as well as specialists.) The table also shows the ratio of members to doctors -- the number of members to be treated by every one network physician. Thus, the lower the number the more access the consumer should have to

physicians in the network. The results of this ratio are mixed, with five HMOs having improved access in 1994 from 1990. Using this ratio, Oxford Health has the most access to physicians.

Table VI-2. Number of Physicians in HMOs: 1990 and 1994

Company	*1990 Total #*	*1990 Members-to-Doctor*	*1994 Total #*	*1994 Members-to-Doctor*
Aetna	2,667	8	4,882	15
Cigna	1,985*	28	3,764	34
CHCP	2,913	38	3,783	23
Connecticare	1,061	99	3,000	33
Kaiser * (staff model)	33	Not applicable	49	Not applicable
MD Health (1991)	2,445	19	4,960	23
Oxford* (Licensed in 1993)			1,670	6
Physicians' Health Services	2,255	58	3,896	12
Prudential	442	5	644	8
Suburban	119	15	325	8
U.S. Healthcare	669	18	2,317	14

Source of data: Best's Managed Care Reports 1995 Edition

Employers indicated they and their employees look at provider networks when choosing a health plan. This is verified by a national survey of employers conducted in 1995, and discussed in Chapter IV. To be competitive, HMOs must offer adequate networks with a substantial choice of providers; otherwise, purchasers will not choose those plans. Further, some HMOs require that the physician meet access guidelines, for example, waiting time for appointments.

Regulations requiring "any willing provider" is antithetical to competition and would handicap managed care efforts to select qualified physicians and control costs. Setting standards for network panel numbers could be cumbersome, and, in fact, does not guarantee access as long as providers may serve on multiple panels. *In light of the above, the program review committee found that HMOs must balance the need to have broad enough networks to satisfy consumer and employer demand with the need to select high quality providers who will provide good health care at reasonable costs.*

Profiling Providers

Once selected, providers must maintain some accountability for their practice standards established by an HMO. HMOs collect and use utilization review data as well as claims information to assess physician performance compared with their peers. This process, termed utilization

management or "profiling", uses the statistics gathered on costs incurred and services used by a particular physician contrasted with others. An HMO uses the profile to bring attention to a physician's practice patterns, and where they differ from the HMO's expectations, to signal areas where the physician should employ corrective action. Physician payment can also be affected by how well he or she manages the use of health care services, and ultimately if a physician falls continuously outside the norms established by the health plan, the HMO may remove the physician from a network.

The National Committee for Quality Assurance examines how each HMO conducts utilization review and management as part of the accreditation process. The NCQA, HMOs, and several large employers told the program review committee that the utilization review process makes physicians more accountable and lessens unnecessary procedures and costs.

In contrast, physicians who attended program review focus groups stated that utilization review interferes with the patient-doctor relationship, obtaining approval for treatments takes physician time away from patients, adds to the administrative burdens of the physician's office, and does not lower costs, but just shifts them to more bureaucratic functions.

Physicians also expressed concerns that HMOs use "deselection" (e.g. termination or not offer to renew a contract) of providers that question HMO decisions, ask for extensions on length of stay, or otherwise disagree with health plan reviewers. The committee asked each Connecticut HMO to indicate the numbers of providers who were terminated or not selected again at the time of credential review. Table VI-3 shows the number of physicians and other providers "deselected" in 1994 and 1995.

In the case of Cigna, the 65 physicians were dropped because of competitive contracting. The company did not renew contracts with 65 physicians associated with a particular hospital. Similarly, BlueCare noted in its response that approximately 65 physicians will not be renewed after 1996 because they are not board-certified, which is one of the new criteria the plan is implementing. However, in both cases, the percentage of physicians whose contracts were terminated or not renewed is less than 2 percent of the total number of physicians under contract with that HMO. For the other HMOs, the table shows that for the period examined, few providers have been deselected or failed to have their credentials reapproved. Thus, the committee believes that physician concerns about being "deselected" by health plans are not borne out by the numbers.

Profiling Factors. The program review committee also requested each HMO submit materials it uses to profile physicians and to indicate how frequently they are reviewed. Most HMOs indicate they profile a physician at least once every two years as part of the credential review process. For those physicians with greater patient volume, the reviews are done quarterly or twice a year.

Table VI-3. Physicians and Other Providers Deselected by HMOs: 1994-1995.

HMO	1994		1995	
	Physicians	Other Providers	Physicians	Other Providers
CIGNA	65	0	10	0
Blue Care (CHC)	0	1	2	1
Kaiser*	N/A	N/A	N/A	N/A
Oxford**	N/A	N/A	6	3
Connecticare**				
MD Health	19	1	0	0
PHS	19	N/A	11	N/A
Aetna	2	N/A	0	N/A
U.S. Healthcare	0	N/A	0	N/A

*Kaiser did not start contracting with physicians until recently; until then Kaiser only had staff physicians.
** Oxford was only licensed in 1993, and did not begin operations until 1994, and no physician review took place until 1995.
*** Connecticare responded that it has not "deselected" any provider "for cause" in the last five years, but did not release the number of physicians whose contracts were not renewed for other reasons.

Source: HMO Responses to LPR&IC Request for Information

Factors included in the profiling reports include patient demographics, physician activities, referrals, and other utilization measures. Some HMOs that submitted their profiling material made allowances for the severity of illness of the patient population, while others did not. Physicians expressed concerns in focus groups about this issue. The program review committee agrees that not accounting for severity of illness in any peer evaluation instrument -- which may impact provider compensation and ultimately retention on the plan -- might deter physicians from taking sicker patients or those with chronic conditions such as asthma or diabetes. It is predictable that a physician with a sicker patient mix would utilize more services and cost more than other physicians with a healthier caseload. Ultimately the failure to recognize illness or conditions in the patient mix when evaluating physicians may lead to "cherry picking", where only the healthy clients are selected for the entire health plan and sicker patients must go elsewhere.

Therefore, the Legislative Program Review and Investigations Committee recommends that any evaluation tool used to profile or measure physician performance shall make allowances for the severity of illness or condition of the patient mix. Written documentation of how this factor is accounted for must be available to the insurance department as part of any market conduct review of any licensed HMO or utilization review company that evaluates physicians on contract. Further, consumers, physicians, or other providers should be informed, upon request, regarding how a health plan considers patient mix when evaluating a provider.

The program review committee believes HMOs should be able to profile physicians, and agrees it brings added physician accountability to the health care system that was lacking prior to managed care. However, the committee concludes that any tool health plans use to profile or measure physicians must not build in a disincentive to caring for sicker patients or those who suffer from chronic conditions. Otherwise, such profiles are not fair evaluation tools of physicians and lead to marketplace anomalies and harm to the consumer.

Rhode Island, in its 1996 legislation dealing with managed care, required consideration of severity of illness in a physician's case mix when they are profiled. Further, there are products on the market that can conduct such assessments for severity through an automated process. Therefore, this recommendation should pose no great burden for health plans.

Contracting

Health maintenance organizations contract with physicians, physician groups, hospitals and other health care providers. Contracts are statutorily required to be in writing and the insurance department reviews the language before it approves licensure of an HMO. Contracts cover such areas as accessibility of medical services, member medical records and confidentiality of those records, utilization management, compensation, and arbitration of disputes between the contracting parties.

The committee concludes contracts are legal documents between the signing parties, and that regulation, in general, should not dictate language nor unduly interfere with legitimate business practices. However, committee members believe that concern over interference with contract language is outweighed by concern for protecting the consumer. The consumer is the recipient of services, but is an outside, non-signing party to these contracts. Where clauses may have negative consequences for the consumer, the program review committee determined certain regulation is appropriate. Four contractual issues that have an impact on consumers are: *gag clauses; disclosure of compensation to physicians; legal liability of health maintenance organizations; and notice of termination.*

Gag Clauses

Gag clauses contractually prohibit physicians from disclosing certain information to their patients. Physicians repeatedly raised "gag clauses" as an issue at focus group meetings and public hearings, interpreting these clauses to prohibit them from discussing with their patients treatment and procedures that are not covered in the plan. Program review asked the Connecticut State Medical Society to furnish examples of such "gag clauses" that prevent discussion of treatments. The state medical society furnished a copy of the American Medical Association's testimony before Congress objecting to "gag clauses" in principle, and provided two examples of cited below:

> **Example 1.** *A physician proposing to terminate a Member for any reason must consult with [XHMO] before communicating with a Member regarding a proposed termination. Physician shall not at any time (I) disparage [XHMO] or the PPO network to any Member or any Health Plan or (ii) advise, solicit, influence, or induce any Health Plan to diminish or terminate its relationship with [XHMO].*
>
> **Example 2**. *[A] Physician shall not, directly or indirectly, counsel or advise any Member to disenroll from any Plan or to access a similar program or product through any person or entity other than [YHMO]. In no event shall Physician market or offer to members services beyond those which are Medically Necessary or which are prescribed by the referring Participating Physician.*

In addition to the samples provided by the Connecticut Medical Society, program review staff also located the following example:

> **Example 3.** *Independent Practice Association (IPA) and IPA providers shall not (I) disparage [ZHMO] to any Member; (ii) advise, solicit, influence or induce or attempt to advise, solicit, influence, or induce any Member to disenroll from any [ZHMO] health care plan or enroll in any other health care plan that would require such Member to disenroll from a [ZHMO] plan. Furthermore, IPA and IPA providers shall not take any action or make any statements that could tend to influence or induce employers or other entities with which [ZHMO] has entered into group membership agreements to cease doing business with [ZHMO] or diminish or otherwise adversely affect their business relationship with [ZHMO].*

The program review committee acknowledges that without a court decision setting a precedent as to the interpretation of these clauses, stipulations like the ones above may be interpreted in different ways. Also, since these clauses appear in the contract, physicians know or should know what they are agreeing to, and if they find such clauses objectionable, they have the option of not signing the contract. Health maintenance organizations may contractually disallow disparagement of the plans by their contracting providers. However, if the prohibition of the plan goes as far as to prevent physicians from discussing treatment options with their patients, as in Example 2, or if the

possibility exists of interpreting the clause as such a prohibition, as with the other examples, then the committee believes this is anti-consumer, and should not appear in the contract.

Therefore, the program review committee recommends that any contract between an HMO and a provider or providers be prohibited from including any clause that prevents the provider from discussing treatment options with a patient. The Department of Insurance shall require that all currently licensed plans submit for review by July 1, 1997, the contract language in force between the plans and their providers.

The Department of Insurance already has responsibility to review contract language between HMOs and providers, so new statutory authority is not necessary. However, that review authority is currently limited to pre-licensure, and thus the recommendation requires the submission of current contract language. The insurance department will then examine the contracts for clauses that impose limits on physicians discussing treatment options, or clauses that could appear to impose such a prohibition, and disallow them from appearing in contract.

The committee believes that after the recent negative publicity surrounding gag clauses most health plans will now revise their contracts and remove these type of clauses on their own. U.S. Health Care recently sent a notice to all its physicians revising its previous position on what physicians might discuss with their patients. The program review committee is confident that other HMOs having such restrictive clauses in contracts will remove them, before the Department of Insurance tells them they must.

Disclosure of Compensation

There are limited ways that a physician can be paid -- fees for each service provided (either at full price or at some discount); a set amount for each patient under the provider's care (capitation); or a salary if the physician works for a staff model HMO. Some HMOs withhold a certain percentage of compensation due a provider until an accounting period has ended to examine how well the HMO and the providers are doing at holding down costs.

At committee public hearings and other forums, physicians and others expressed concern that consumers may be unaware that HMOs compensate physicians in a way that might provide a disincentive to providing medical care. The program review committee believes managed care plans should not be prevented from compensating physicians and other providers any way they like, as long as those parties agree in contract. Capitation as a method of compensating providers is one of the basic principles of managed care. It places some of the financial risk with the physician to hold down costs. To ban capitation would force managed care organizations to return to a fee-for-service method that inherently offers incentives for additional services and treatments, and was unsuccessful in containing costs. Also, a recent court ruling in New York dismissed a lawsuit brought by physicians and nurses against Aetna challenging the capitation method of paying providers.

Even though capitation may be a legitimate method of compensation, the committee also concludes that methods of provider compensation should be disclosed to patients if they wish to know. In fact, the committee proposes that the method of payment be reported to the insurance department so that it be included as part of its consumer information report on HMOs.

Therefore, the program review committee recommends that the Department of Insurance shall review contract language between HMOs and providers to ensure that no clauses prohibit a provider from discussing the method of compensation with a patient, if the patient asks. Further, each HMO as part of its annual filing with the insurance department shall disclose its method of payment to physicians and other providers. The insurance department shall report this information as part of its consumer report on health care plans.

The HMOs and other insurers would not be required to divulge individual payment amounts, only method of payment (fee-for-service or capitated), and whether there is a withhold or not. In this way, consumers -- employers and individuals -- would have access to the method of payment information, but HMOs would not be forced to release information on actual payments or discounts to competitors. In fact, method of payment information would reveal less about payment than actual rate information that HMOs must currently file.

Financial Hold Harmless Clauses

When Congress passed the Federal Health Maintenance Organization Act in the early 1970s, one of its goals was to promote an alternative to traditional health insurance. One of the major differences between HMOs and traditional health insurance that was crafted by Congress in the legislation is the "hold harmless" feature of the HMO. The federal legislation requires that each HMO "protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the HMO." (42 CFR Ch IV S 417.122).

Connecticut statutes also require that written contracts between providers and HMOs include a clause that guarantees the subscriber will not be held financially responsible for an HMO's unpaid bill. Staff of the insurance department review the written contract language to ensure this clause is included.

Providers indicate this poses a problem where there is a disagreement between the health plan and the physician about what is medically necessary, and the provider is left with the financial responsibility for the treatment if it is provided. For example, a physician may determine a hospitalized patient needs additional days, and the plan may disagree. Unless the hospitals inform the patient the health plan is denying the authorization of a particular service or extension, and the patient wishes the service or extension despite the denial of the health plan, hospitals must absorb the costs. Committee staff interviews with three hospital financial administrators indicated hospitals are required both by law and by contract to follow these "hold harmless" clauses.

Further, according to staff at the Office of Health Care Access, which receives budgetary data on all hospitals, losses incurred because of the "hold harmless" requirements must be borne by the hospital as part of the overall discounts they agree to as part of their contracts with HMOs. Hospitals are prohibited from including this type of debt in the uncompensated care pool, which is supported by a hospital tax that is then redistributed among them depending on each hospital's portion of care to the uninsured. Audits of hospital accounts would disallow "hold harmless" debt in uncompensated care, if detected.

The program review committee believes that "hold harmless" clauses were incorporated in the federal HMO Act as a method of containing health care costs, by prohibiting physicians, hospitals, and other providers from billing patients for the balance of bills that HMOs will not pay. If providers were allowed to pursue the patient for the portion of costs beyond the HMO discounts, the pre-arranged co-pays and reduction in fees would become meaningless, and costs to the consumer would soon rise. Thus, the committee concludes that the "hold harmless" requirement has become one of the cornerstones of managed care, and should be continued.

Legal Liability of HMOs

Physicians also indicated that HMOs are immune from legal liability. Legal liability concerning medical issues is murky. Beneficiaries may sue a health plan for medical liability, but courts have also limited their remedies.

Impact of ERISA. Health plans may sometimes attempt to dismiss the suit on the grounds the health plan is an ERISA one, but the courts have been indecisive about when such ERISA preemption is allowed. Some courts have said if the suit arises out of the obligations of a benefits contract, then it "relates to" an ERISA plan, and the plan is preempted, and no suit in state court is allowed.[14]

Other state courts have found that if the claim involves a medical treatment question, then no ERISA preemption is allowed and the lawsuit may proceed. Then, the legal issue becomes whether the doctor or the health plan made the medical decision. In these cases, too, courts have not been uniform in their decisions. Court decisions holding health plans responsible have usually found some defect in the design or implementation of the health plan's managed care process (e.g., poor credential review, using medical protocols inconsistent with local practices).

If the case is heard in federal court, remedies under ERISA are limited. ERISA was designed to ensure that health plan assets are used for health benefits and not damage awards, which would drive up premiums. Therefore, under ERISA plans, enrollees may sue for the benefit but not for

[14] In cases of legal liability, ERISA plans are interpreted broadly as any employer based plan, whether self-funded or not. For the most part, all employees fall under ERISA plans except for government and church employees.

damages, although plaintiffs, at the court's discretion, can recover legal fees if they prevail. Hence, doctors typically provide a more successful target for suits involving medical issues.

Individual claimants not covered by ERISA may sue under state causes of action and may claim damages. Under state malpractice laws, these plaintiffs are allowed to factor in loss of income, emotional and physical injury in calculating compensatory damages and to ask for punitive damages. As a result, these awards can run into millions of dollars. Thus, one of the criticisms of the ERISA act is that it does not provide the extent of procedures and damages available under state law, and therefore disadvantages participants in ERISA plans relative to individuals covered outside of ERISA. However, while ERISA preemption may deny certain plaintiffs a corporate "deep pocket", it does not leave them totally without remedy. ERISA plaintiffs still retain the traditional medical malpractice, wrongful death, and related tort actions against the independent health care provider.

Physicians are required by health plans to carry malpractice insurance, and suits may affect the professional reputation of the physician through reports of those payments to the national practitioner databank. The databank is available to insurers and health plans who use the data to select physicians to serve on a plan's panels.

Indemnification clauses. Contracts between health plans and providers also deal with legal liability issues. These contractual clauses generally state that the relationship between the health plan and the providers is that of independent entities contracting with each other solely for the purpose of effecting the provisions of the agreement. As such, neither party shall be liable to any other party for any act or failure to act of the other party to the agreement. Providers claim these clauses allow health plans to be held harmless from any claims, damages, or other liabilities arising from services rendered by the provider. *The program review committee found that these indemnification provisions are clauses restrictive to only the signing parties, and thus does not believe they prevent or prohibit consumers from seeking legal remedies from the parties independently.* **Nevertheless, the program review committee recommends a statutory provision clarifying that a consumer may sue a health plan. The statute shall indicate that contractual provisions between an HMO and a provider do not prohibit any other remedy, cause or causes of action that the member, beneficiary, or insured may otherwise have by reasons of statute, common law, or contract.**

The program review committee believes nothing currently prohibits any enrollee from filing a suit, and this position is strengthened by the recommendation. However, as the discussion above illuminates, legal accountability of health plans is complicated by ERISA and a number of judicial decisions. The committee concludes there is no state legislative remedy that will clarify the ERISA clouding of legal liability. This issue requires a federal remedy.

In the absence of any amendment to ERISA, the federal courts will decide the degree to which ERISA plans are subject to liability for quality of care decisions. Increasingly, courts are looking at the actions of managed care plans with respect to credentialing and selection of health care providers, coordination of care, preauthorization of treatment, and review of claims. The courts' growing willingness to judge managed care entities by the same standards as they do other health care providers appears to be heading toward additional avenues of redress for the consumer.

The committee's conclusion that HMOs can be sued is supported by the fact many of them were named in lawsuits at least once during 1995, and most of them protect against that exposure by purchasing professional liability insurance. Table VI-4 provides the amount of liability insurance carried by HMOs and the number of litigation/lawsuits reported to the insurance department in the HMOs' annual financial reports.

Legal commentators have suggested the limitations of judicial remedies appear to have a dampening affect on the number of lawsuits brought against ERISA plans. It is speculated that some employees do not file grievances out of fear of retaliation such as job loss, while other employees willing to pursue an appeal may have a difficult time finding lawyers to litigate because of ERISA's limited damages and attorney's fees. This in turn has resulted in few lawyers having expertise in ERISA health plan litigation.

Table VI-4. Legal Liability Issues Related To HMOs -- 1995

HMO	Professional Liability Insurance	Suits Involving Medical Issues	Suits related to other matters
Aetna	yes --$5m	none	none
Cigna	yes -- vicarious medical malpractice --$5m	2 dismissed 2 settled	2 -- Hollis and Napoletano (see Appendix C)
CHCP (Blue Cross)	yes -- $5m/$15m over self-insurance of $250k/$750k	3 pending	2 -- alleged breach of employment contract and employment discrimination
Prudential	yes --$25m after $1m deductible	none	none
Suburban	Yes --$3m/$3m	none	1 -- alleged wrongful termination
U.S. Health	Yes-- $34.5m /$36m in excess of $500k/$1m self-insurance	1 pending	none
MD Health	Yes -- $500k/ excess to $40m	1 settled 1 pending	Annual report indicates former Directors and Officers claim (No attachments provided)
Oxford	Yes -- $30m.	none	none
Connecticare	Yes -- $10m.	none	none
Kaiser	Self-insured $15m	6 pending	none
Healthsource	Yes -- $10m/$10m	No 1995 business	No 1995 business
PHS	Yes -- $10m/$10m	none	"various litigation and claims arising in the normal course of business . . . which management believes will not have a material impact on company's financial position" (No further details provided)

Source of data: 1995 HMO Annual Reports

Termination of Providers

Finally, another area at issue involving contracts between health plans and physicians is the right to appeal when a provider's contract is not renewed. Currently, contracts allow providers appeal rights to the health plan, including arbitration, if the physician is terminated "for cause". Guarantees of due process resulting from termination from a hospital or health plan for reasons of incompetence or professional conduct grounds are guaranteed pursuant to the federal Health Care Quality Improvement Act of 1986. Similar appeal rights have not been granted for "without cause" termination, which include economic or business reasons or because a health plan does not believe a provider is practicing good utilization management.

Courts had traditionally rejected any claims brought by physicians regarding "without cause" terminations, since physicians and health plans had entered a contractual relationship with those clauses clearly spelled out. A recent New Hampshire Supreme Court decision, however, found in favor of a physician in that state who was terminated "without cause". The ruling did not indicate all economic or business terminations are invalid, but such terminations that can be demonstrated to have been done in bad faith or are contrary to public policy could be a cause for legal action.

The program review committee believes the courts present the best course of action for physicians who believe they have been wrongfully terminated "without cause" by an HMO or a managed care organization. Legislative action spelling out how and when a health plan may terminate its physicians would be misplaced government intervention in the marketplace as well interfering with contracts themselves.

Just as a health maintenance organization should be able to initially select their providers, they should be able to terminate, or not renew, a contract with them as well. As long as both parties follow the contractual obligations to which both parties have agreed, HMOs are conducting their operations as any other business does with independent contractors.

Notice of termination. Connecticut statutes require that agreements between providers and health plans be in writing. Further, the statute mandates that the provider give "at least 60 days advance notice to the health care center to terminate the agreement" (C.G.S. § 38a-193 (3)(e). No such requirement exists for health plans to provide minimum notice requirements to providers in order to terminate the agreement.

Providers should be given the same statutorily guaranteed notice requirements as health plans, except in cases where keeping a physician on contract poses a threat to the safety or health of patients or enrollees. Further, the program review committee believes that consumers, as well as physicians, need prior notice when a physician's contract is being terminated or not being renewed.

Prior notification of a non-renewal or termination will provide consumers with a medical transition period. For example, consumers might find a replacement physician within the network prior to actually needing a medical appointment rather than finding out their physician is no longer part of the network when they need medical attention. Prior notification to consumers could also help with a transition of medical care, where final medical procedures could be conducted prior to termination, or the patient's medical records could be transferred to the newly selected physician before the termination date.

Thus, both to provide equal notification guarantees, and to introduce a consumer notification requirement **the Legislative Program Review and Investigations Committee recommends that Section 38a-193(3)(e) of the statutes be modified to include a 60-day notification to providers by a health care center prior to terminating an agreement, except in cases where that provider poses a danger to the health or safety of plan enrollees. Further, plan enrollees shall be notified at least 30 days prior to the contract termination of a provider.**

APPENDIX A
Agency Response

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

January 24, 1997

Michael L. Nauer, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106-1591

Dear Mr. Nauer:

Thank you for forwarding a copy of your report to the Legislative Review Committee regarding the regulation of managed care. I would like to commend your staff members Catherine Conlin and Michelle Castillo for their professionalism, thoroughness and objectivity in carrying out this study and preparing the report. I believe that all parties of interest, including the Insurance Department, will find this work product extremely enlightening and helpful. As you know, we have also independently been reviewing the issues of managed care and utilization review. Many of the findings in your report and our study to date are very consistent.

Based on our study, the Insurance Department has already implemented the following changes to improve the regulation of utilization review. Our Consumer Affairs Division is being restructured into two units; one unit headed by a newly appointed principal examiner is concentrating on life and health issues, and the other, also supervised by a principal examiner, is concentrating on property-casualty matters. The complaint coding and tracking system utilized in the unit is in the process of being modified for consistency and to adapt to the constantly changing industry. In addition, market conduct examination procedures for utilization review companies have been developed, with the first comprehensive examinations for these companies scheduled to begin in the very near future.

As we finalize our review, we hope to have the opportunity to further benefit from your findings; an example being the matter of preparing a report card on managed care companies for the consumer. We share this goal, but will need to determine how to best develop such a report so it is extremely helpful to the consumer and developed in a cost effective manner. There will be other matters we will also want to discuss in detail.

Again, thank you for the opportunity to have the benefit of the report and be assured that we will keep you advised of the finalization of our study.

Sincerely,

George M. Reider, Jr.
Commissioner

Phone:
P. O. Box 816 Hartford, CT 06142-0816

APPENDIX B
Connecticut Benefits Mandates

Appendix B

Connecticut Benefit Mandates: A Comparison		
Coverage	*Insurers*	*HMOS*
Standard provisions for how individual policies should be written	Must comply if the insurer offers individual policies but they are not mandated to offer such policies	HMOs are not mandated to offer individual policies
Pre-existing Condition: exclusion of coverage for pre-existing conditions is allowed, but must not extend beyond 12 months from date of coverage, and can not look back more than 6 months	Statute applies to both individual and group policies	Statute applies to HMOs, but because of the manner services are delivered, it is not applicable. If the group is accepted, all enrollees within the group are covered for all provided services from date of coverage.
Dependent Children Coverage to Continue if child is physically or mentally handicapped and chiefly dependent on subscriber or policyholder for maintenance and support	Yes	Yes
Termination of Coverage of Dependent Children no earlier than 19 or date of marriage (whichever occurs first) or 23 if a full-time student	Individual policies only	Individual policies only
Mammograms: Baseline 35-40; every 2 years 40-50; yearly 50+	Yes	Yes
Preventive Pediatrics (well-baby care)	Group policies (bought through employer) must cover but not individual policies	Yes
Newborn care including adopted babies including coverage for birth abnormalities and congenital defects	Yes	Yes
Mental illness: 60 inpatient days per calendar year; or 120 days of partial hospitalization (at least 4-hour sessions); Outpatient care at 50% of covered expenses to a maximum of $2,000	Yes	Yes, but statute states that, other than emergency or referral made by doctor affiliated with HMO, HMO is not required to provide benefits at facilities not affiliated with the HMO
Home health care provided it is given by a licensed, federally certified home health agency and at least one physician and one RN oversee services. Coverage may limit the number of visits, but to no fewer than 80 per 12-month period	Yes	Yes

Coverage	*Insurers*	*HMOS*
Emergency care due to accidental ingestion of controlled substance	Yes	No
Medically necessary ambulance services	yes	Yes
May not exclude benefits provided at Veterans Home and Hospital	Yes individual and group health policies	Not clear
Comprehensive Rehab	Insurers must offer in group plans, but employers don't have to purchase; Insurers don't have to offer it in individual policies	Mandated to offer to groups
Occupational therapy	If physical therapy is covered, occupational therapy must be covered - - group and individual	Same mandate as regular health insurers
Cancer -- Removal of tumors, treatment of leukemia including outpatient chemotherapy, reconstructive surgery and non-dental prosthesis. Minimum amounts mandated are $500 for each mandated service, except $300 for prosthesis	Yes	Yes
Breast implant removal for those done before July 1994 regardless of reason, minimum $1,000	Group policies only	Group policies only
Services provided by certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse midwives	Yes, if services provided are covered if provided by other licensed health care providers	Yes, if services provided are covered if provided by other licensed health care providers
Chiropractic Services	Yes for individual and group policies	Not mandated
Infertility Services	Required to be offered for group policies, but employers do not have to purchase it	Same mandate as regular health insurers
Substance Abuse Treatment: hospital treatment related to alcoholism or substance abuse must be covered; Confinement to treatment facility coverage - at least 45 days within 12 consecutive months.	Mandated for group policies but not individual policies.	Same mandate as regular health insurers

Coverage	*Insurers*	*HMOS*
Outpatient Substance Abuse Treatment at licensed treatment facility	Required to offer it in group policies, but employers don't have to purchase it	Same mandate as regular health insurers
Work-related injuries for sole proprietors, partners, and corporate officers	Mandated for group and individual policies, but would have subrogation rights on monetary recoveries	Same mandate as regular health insurers
Prescription Drugs	Not mandated but if covered cannot require patient to obtain drugs through mail order	Same mandate as regular health insurers
Prescription Drugs	Not mandated but if covered must not exclude drugs that have not yet received FDA approval but are recognized by 1 of 3 reference groups as recommended for treatment of certain cancers	Same mandate as regular health insurers
Hypodermic needles and syringes prescribed by licensed practitioner	Mandated for group and individual policies	Same mandate as regular health insurers
Special health care plans for small employers	Mandated	Mandated with certain exemptions provided in statute

Source: LPR&IC Staff Analysis

APPENDIX C
Employee Retirement Income Security Act (ERISA)

APPENDIX C
Employee Retirement Income Security Act (ERISA)

ERISA preemption has become of significant concern to health plan sponsors, health plans, and participants. In particular, the division of federal and state responsibility for the regulation of health benefits has become a confusing area of law. A three-part analysis is used to determine whether ERISA preempts state law. First, preemption is presumed if the state law "relates to" any employee benefit plan. Most courts find that ERISA preempts any state law having *any* impact on an ERISA qualified plan. Second, a state law relating to an employee benefit plan may be "saved" from preemption under ERISA if it regulates insurance, banking, or securities. With regard to health care benefits, the regulation of insurance is the most pertinent to determining whether state law is "saved" and therefore, not preempted. The third step of the ERISA preemption analysis concerns the "deemer" clause. State insurance regulation may be saved only to the extent that it regulates genuine insurance companies or insurance contracts. Therefore, state regulators may not "deem" an employee benefit plan to be an insurance plan in an effort to avoid preemption if the benefit plan would not otherwise qualify as an insurance company or contract. As a result, the deemer clause limits the application of the savings clause to conventionally insured employee benefits plans and arguably excludes self-insured plans.

A self-insured plan does not carry on the business of insurance since the policyholder does not transfer risk or spread risk across a pool larger that the policyholder itself. Self-insured plans frequently contract with insurance companies to provide administrative services to such plans. In this respect, the insurance company acts only as a non-insurer/third party administrator providing managerial functions.

Although intended to protect employees, employers, especially interstate employers, favor ERISA because of its broad preemption of state law. In addition, ERISA imposes virtually no substantive requirements regarding employee benefit plans. Because ERISA does not mandate that benefit plans be provided or maintained at any particular level, an employer can revise such a plan without the consent of the employee. An employer is free to increase or reduce benefits without notice to or consent of the employee. ERISA only requires that a plan not discriminate against participants or interfere with or retaliate for a participant's exercise of rights under the plan.

Judicial Interpretation of ERISA Preemption

There are a number of gray areas where the division of federal and state responsibility is unclear and where the courts have resolved the issues rather ambiguously. In general, these questions arise in situations where self-insured plans arrange to share substantial risk with entities that are either in the business of insurance or engaged in practices that are similar to insurance operations.

A recent U.S. Supreme Court decision held that ERISA does not preempt state laws that do not refer explicitly to employee health plans even if they impose some administrative burdens and

costs on such plans.[1] The Court stated that Congress must have intended some limits to preemption and that indirect effects on employee health plans are preempted only when they affect plan benefits, structure, and administrative requirements. The Court recognized, however, that ERISA could preempt a state law imposing costs so high that it would effectively influence a plan administrator's behavior.

Currently, it is not clear whether state regulation of HMOs, PPOs, or utilization review companies can be thwarted by ERISA. The courts continue to reach conflicting results in determining whether such entities are insurers subject to ERISA. In a recent Connecticut Supreme Court ruling, a challenge to a PPO's decision to remove a provider from its network was considered not to be preempted by ERISA.[2] In the *Napoletano* case, nine physicians, in conjunction with a group of their patients, alleged that Cigna had engaged in unfair and deceptive acts of misrepresentation and false advertising. The physicians alleged that although they continue to be board-certified in their area of speciality and continue to satisfy Cigna's credentialing standards, Cigna unilaterally terminated them without just cause and denied them the opportunity to reenroll as a participating physician in the Cigna network. The patients were participants in the Cigna health plan. They alleged that Cigna provided them with various assurances that their physicians who met Cigna's credentialing standards would continue to participate in their health plan. Among other things, the patients claimed that Cigna listed their physicians as a Cigna providers with the state Commission on Hospitals and Health Care and sent them a directory of providers, which included their physicians, but failed to inform the enrollees in its plan that participating physicians could be removed from the list without notice.

Cigna argued that the claims asserted by the plaintiffs were preempted by ERISA because they "relate to" the health care plan that Cigna administers in that they deal with the administration of the plan. Cigna asserted that the claims directly challenge the propriety of the plan's administration and Cigna's decision to restructure the health coverage that it offers. The court held that the plaintiffs' claims were not preempted by ERISA because their claims did not affect or prescribe the establishment, administration, regulation, or maintenance of an employee benefit plan but instead sought to have the defendant enforce the plan it had chosen to create and administer. The court concluded that the claims did not "relate to" employee benefit plans within the meaning of ERISA's preemption provision.

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[1] *New York State Conference of Blue Cross &Blue Shield Plans v. Travelers Insurance Co.*

[2] *Napoletano v. Cigna Healthcare of Connecticut ; Hollis v. Cigna Healthcare of Connecticut.*

APPENDIX D
Summary of Managed Care Regulation in Other States

Appendix D: Summary of Managed Care Regulation in Other States

The following provides a brief synopsis of the regulatory measures in California, Florida, Massachusetts, Minnesota, Texas, Maryland, New York, and New Jersey.

California

Regulating authority. California's managed care is primarily regulated by the Department of Corporations. HMOs must obtain state licensure prior to beginning operations. As part of their licensing requirement, HMOs must submit their method of supervising marketing conduct. They must also submit the names and rate of compensation of all persons marketing the plan. Each applicant must also ensure there is adequate service coverage for each region or service area. Each organization must demonstrate that access to care is reasonable and must include travel and distance assessments as well as probable waiting times for scheduled appointments.

California law prohibits HMO-initiated disenrollment except for failure to pay the premium, fraud, or other good cause. Medical underwriting must be completed prior to enrollment. If the commissioner determines that disenrollment is improper, the HMO may be required to reinstate enrollee or request a hearing.

Advertising prohibitions. California has a prohibition against false advertising for an HMO. The statute provides definitions of what constitutes deceptive, misleading, and untrue advertising. If the state determines the HMO has conducted false advertising the commissioner may require that a correction or retraction, approved by the commissioner, be published in the same medium in which it was originally ran.

California requires state approval before use of marketing materials. If the HMO has been licensed for 18 months, it may be used without prior approval, but must be filed with commissioner within 10 days of publication. In addition, there are limitations on the use of pricing in marketing materials.

Physician accessibility. Regulations stipulate that the enrollee-to-staff ratio be adequate to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. Specifically, the regulations require each HMO have at least one full-time physician to each 1,200 enrollees and one full time primary care physician for each 2,000 enrollees or an alternative mechanism to demonstrate an adequate physician/patient ratio. Each applicant must also demonstrate adequacy for each region or service area.

Each HMO must submit a description of their system for monitoring and evaluating accessibility. The system must demonstrate that primary care physicians and hospitals are located within 30 minutes or 15 miles of enrollees' homes or work places or otherwise reasonable accessibility and include an assessment of probable waiting times for scheduled appointments.

Utilization management. Utilization reviewers must have education, training, and relevant expertise pertinent for evaluating the specific clinical issue. Referral standards must be disclosed to the commissioner, contracting providers, and any enrollee upon request. The referral standards must be developed by practicing health care providers using sound clinical principles and be updated at least annually.

HMOs may not require prior authorization for emergencies. HMOs must pay for any out-of-plan emergency care provided except if the enrollee reasonably should have known that an emergency did not exist.

Enrollees denied approval of experimental procedures for terminal conditions/illness which will result in death within a year must be given: 1) a notice detailing the medical and scientific reasons for denial; 2) a description of alternative (if any) covered treatment, and 3) a copy of the grievance procedure. The grievance process must provide for a hearing within 30 days or within five days if physician determines it is medically necessary to derive effectiveness of proposed treatment.

Quality assurance measures. At least once every three years the Department of Corporations must conduct an onsite medical survey of the health delivery system of each HMO. The surveys must include a review of utilization patterns, peer review mechanisms, complaint handling process, and quality assurance measures. HMOs must be notified four weeks before the onsite survey. The department may contract qualified health professionals to perform the medical surveys. The final report must include all compliance efforts and remedial measures taken. All surveys must be made open to the public 45 days after the HMO has received the report. Eighteen months after the final report, the department must conduct a follow-up review to reassess the status of any deficiencies. This information shall not be made available to the public if deficiencies are corrected within 30 days.

Grievance/appeals system. Each HMO must establish written grievance procedures which provide for written notice of the complaint disposition within 30 days. Enrollees must be notified of grievance process at the time of enrollment and annually thereafter. Complaint forms must be made available to enrollees wishing to make a complaint.

Each HMO must designate an officer to examine complaint trends and implement a system to track complaints not resolved within 30 days. The commissioner must be given a quarterly report with a brief explanation of the reasons each complaint was not resolved within 30 day time period. After 60 days in the grievance process, an enrollee may appeal to the state for review. HMOs must publish this statement as part of their grievance procedures.

Data collection/reporting requirement. HMOs are required to disclose substantial provider information including percentage of the physicians' time allotted to the plan; the availability of physician appointments; after hour and emergency services; probable patient waiting times; and the proximity to specialists and hospitals. Applicants for HMO license must describe their risk sharing arrangement and ensure that medical decisions are rendered by qualified physicians unhindered by

fiscal and administrative management. As mentioned earlier, HMOs must submit quarterly reports of complaint resolutions.

Solvency protections. The commissioner must conduct a financial examination at least once every five years. Each HMO must have an insolvency contingency plan and insurance or reinsurance agreements. All provider contracts must contain hold harmless clauses.

Legislative activity. Currently, there are several bills pending in the California legislature relating to managed care including legislation:

- requiring health plans to disclose provider financial incentives to the Department of Corporations and prohibiting certain physician incentive plans;
- prohibiting health plans from inserting "gag" clauses in physician contracts that prevent them from fully informing patients about treatment options, alternative coverage arrangements, or other issues that effect patients' health;
- affording health plan members the right to an independent review outside of their plan when denied coverage on the basis that the treatment is experimental or investigational; and
- requiring the Department of Corporations to develop standards to ensure that health plan drug formularies achieve therapeutic efficacy and cost savings.

Florida

Regulating authority. Florida's managed care is regulated by two agencies: Department of Insurance and the Department of Health and Social Services. Every application for a certificate of authority must include biographical and character reports about individuals responsible for HMO operations. Prior to receiving a certificate of authority from the insurance department, a HMO must obtain a health care provider certificate from the health department that ensures its services are accessible with respect to geographic location, hours of operation, provision of after-hour service, and describes staff patterns.

Advertising prohibitions. Similar to other states, Florida prohibits false and misleading marketing. If found to have published false or misleading information, the department may require the HMO publish a correction and levy an administrative penalty. HMO advertising may not create the impression it has been endorsed by any division of the United States government. It may not use any combination of shapes, colors, or phraseology used by agencies of the government that would tend to confuse prospective subscribers.

All forms, rates, and rating methodology must be filed and approved by the department prior to use. HMOs may engage in marketing activities before licensing but may not provide services or

collect premiums or charges until issued a license. Every HMO must maintain marketing files which are subject to state review. Prior to effectuating a subscriber contract, each HMO must obtain written verification that the subscriber intends to join a HMO and understands the restrictions related to its use.

Market conduct. A HMO may not refuse any individual of a subscriber group on the basis of age, health status, health care needs, or prospective cost of services. Enrollees must receive at least 45 days written notice of cancellation, termination, or non-renewal. If the HMO uses physicians, nurses, or other individuals to render health services that are not licensed, this information must be provided in contracts and member handbooks.

Physician accessibility. As indicated above, HMOs are required to establish maximum waiting times and travel distances for care. Travel time to primary care physicians and hospitals shall not be more than 30 minutes under normal circumstances while specialty services must not be more than 60 minutes. These requirements may be waived if the HMO provides sufficient justification why it is not feasible.

HMOs must also establish appointment system whereby:

- emergencies are seen immediately;
- urgent care shall be seen within 24 hours;
- routine symptomatic cases within two weeks; and
- routine non-symptomatic cases seen as soon as possible.

Patients should receive professional evaluation within one hour of appointment.

Quality assurance measures. HMOs are required to have an ongoing quality assurance program evaluating the following components: clinical performance; medication usage; appropriate usage of tests and studies; outcomes of care; subscriber grievances, and physician credentialing. HMOs must maintain a central system for verification and examination of the credentials of each provider including a copy of the provider's current Florida license.

Accreditation. Within one year of receiving the certificate of authority, an HMO must receive accreditation. HMOs may maintain accreditation either through an accreditation organization or obtain review by an external review organization approved by the department. The accreditation or assessment process must include a review of the professional credentials of providers and a representative sample of not fewer than 50 medical records of individuals subscribers. The state must investigate any HMO that does not meet accreditation standards or standards of the external quality assurance review. The insurance department must examine the HMO's affairs at least once every three years.

Utilization management. Florida law states that the professional judgement of a physician concerning the proper course of treatment of a subscriber shall not be subject to modification by an

HMO unless it is inconsistent with the prevailing standards of the medical practice in the community.

If an enrollee disputes the HMO or physician's opinion for the reasonableness or necessity of surgical procedures, the HMO must, upon request, provide the enrollee a second opinion. The enrollee may select a contracting or non-contracting HMO physician. If the enrollee selects a non-contract physician, the HMO may require the enrollee to pay 40 percent of the usual, reasonable, and customary charges.

Data collection/reporting requirements. Biographical and character reports must be submitted for all new officers joining the HMO and must be updated in an abbreviated report every two years after licensure. An annual description of the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of each must also be submitted. Furthermore, HMOs must report the number of health maintenance contracts issued, outstanding, and terminated. In addition, HMOs must annually report to the state detailed information regarding incident reports, medical malpractice claims, and disciplinary actions taken against its providers.

Any adverse incident resulting in death, severe brain or spinal damage, or a surgical procedure performed on the wrong patient or unrelated to the patient's diagnosis or medical needs must be reported to the state within three working days of its occurrence. This information is confidential and not subject to the state's public records act.

Grievance/appeals provisions. Florida HMOs may not be issued a license until an HMO has a satisfactory grievance process in place. As part of the grievance process, HMOs must provide a toll free phone number for subscriber complaints, ensure physician involvement in medically-related grievances, and offer to meet with the subscriber during formal grievance proceedings. Records must be kept of grievances. Specifically, a report must include a complete description of the grievance, factual findings and conclusions, final disposition, and levels of the grievance process the complaint has gone through. Grievances should be handled within 60 days unless it is mutually agreed that more time is needed. Complainants who are still aggrieved may appeal any unfavorable determination upon exhaustion of an HMO grievance process to the Statewide Subscriber Assistance Program. However, the Department of Health may investigate any complaint prior to the completion of HMO grievance process. Any complaint that remains unresolved after departmental review may be brought to Statewide Subscriber Assistance Program.

The Statewide Subscriber Assistance Program consists of a panel of representatives from the regulatory agencies. The panel reviews grievances referred to it and develops recommendations of the appropriate steps to be taken by the regulatory agencies.

Solvency protections. Each HMO must maintain a minimum surplus of $5000,000 or 10 percent of its total liabilities, whichever is greater. Additionally, the HMO must deposit with insurance department cash or securities in the amount of $100,000. This requirement may be waived if the HMO can demonstrate it has adequate surplus and is assured financial viability. HMOs may

enter into reinsurance agreements whereby the subscriber will be protected in the event that an HMO is unable to meet its obligations. The department must approve these agreements. All HMO contracts must state that the HMO, not the subscriber, will be liable to provider, for financial obligations.

Sanctions. The Department of Insurance may levy administrative fines of not less than $100 nor more than $100,000. Failure to file annual reports may be subject to $1,000 a day fine for the first 10 days and $2,000 for every day thereafter up to $100,000. Furthermore, the insurance department may revoke certificate of authority if the HMO fails to comply with accreditation rules.

Massachusetts

Regulating authority. Massachusetts health plans are regulated by the Department of Insurance. As part of the application for certificate of authority, the HMO must provide an organizational chart with titles, employment history, and salaries of key management personnel. In addition, it must also submit information regarding all service areas, existing utilization rates for inpatient and outpatient services, copies of forms, and a plan for yearly publication and distribution of specified information to enrollees. The application must also include an inventory of full time providers by specialty and physician to enrollee ratios and contain staff privileges and the role and function of any non-physician provider.

Each applicant must design a quality assurance plan that reviews a periodic sample of medical records, provider turnover rates, peer review, and utilization data. The application must also provide a description of the grievance process.

Advertising prohibitions. Massachusetts law prohibits marketing methods which create "false or misleading impressions on a person of average education or intelligence." The regulations specify what constitutes deceptive, misleading or misrepresentative information. All health insurance agents must register with the Department of Insurance. Each HMO must maintain records of the amount paid and method of calculating their agent's commission.

Physician accessibility. Enrollees must be provided a 24-hour emergency contact number and a statement of medically necessary emergency service procedures. Massachusetts has adopted a provision that "any willing pharmacy" that meets the terms of the health plan and its criteria and practices may apply and must be accepted.

Data collection/reporting requirements. Quarterly and annually, the HMO must submit enrollment and disenrollment data and utilization information regarding hospital services, emergency services, mental health services, referral care, home health and skilled nursing. A statistical summary of all grievances must also be filed. Each HMO must obtain an annual independent financial audit which must be filed with commissioner.

Quality assurance measures. Each HMO must implement the quality assurance plan that they submit as part of their application for certificate of authority. At least every two years, HMO

operations must be examined by insurance commissioner.

Solvency protections. Each HMO must maintain a surety bond or deposit in an amount satisfactory to the commissioner which will serve as a guarantee that the obligation to enrollees will be performed. This may be waived if there is a preapproved reinsurance agreement. All HMO contracts must state that enrollees are protected against recourse by a provider in the event that HMO ceases to reimburse them. The HMO must also ensure there is continuation of coverage.

Sanctions. The state may revoke or suspend an HMO's certificate of authority if it determines there exists:

- an unsound financial condition;
- continued operations may be hazardous to enrollees;
- fraudulent business practices; or
- a violation of any state law or regulations.

Legislative activity. In January, Massachusetts enacted legislation that prohibits health plans from banning physicians from discussing a plan's financial arrangement with patients. A health maintenance organization shall not refuse to contract with or compensate for covered services of an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former, or prospective patients regarding the provisions, terms, or requirements of the organization's products as they relate to the needs of such provider's patients. A new Massachusetts law prohibits insurers from demanding that therapists provide confidential details about a patient's life history and psychiatric status before receiving payment. Among the issues being examined in the Massachusetts legislature is the number of exclusive contracts that health plans can establish with doctors.

Minnesota

Regulating authority. Minnesota HMOs are regulated by the Department of Health and are required to be nonprofit. The certificate of authority application must include the marketing plan. After one year of operation, the HMO is required to have at least 40 percent enrollee representation on all HMO governing boards.

Advertising prohibitions. Minnesota law prohibits false and misleading marketing. All marketing materials must boldly state the following language "THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES, READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED". The HMO telephone number must follow this language.

Forms must be approved by the commissioner prior to use. HMO marketing agents must be licensed and disclose their commission rate to potential enrollees.

Market conduct. HMOs operating for at least two years must annually hold an open enrollment period of 14 days. During this open enrollment, the HMO must accept all otherwise eligible individuals in the order they apply. HMOs may request a waiver from this requirement if it would compromise their financial stability or produce unreasonably high charges for enrollee coverage. Each enrollee must receive evidence of coverage that explains enrollees' rights, and conditions for termination of coverage. Enrollees may cancel contracts within 10 days of receipt if they are not satisfied, and have their premium refunded.

Physician accessibility. Each HMO must implement standards to assess provider capacity and timely access to health care services. All HMOs are required to have sufficient and appropriate personnel, physical resources, and equipment to meet the projected needs of its enrollees for covered services. The maximum travel distance or time must be within 30 miles or 30 minutes for primary care physician or hospital and within 60 miles or 60 minutes for specialists and other specialized health care services. The commissioner may grant a waiver for this requirement if the HMO can produce specific data showing these standards are not feasible.

Health plans must accept independent providers who meet credentialing standards, agree to terms of the plan, and who agree to comply with all managed care protocols. This applies only to non-staff model HMOs with more than 50,000 enrollees and to non-physician providers.

Utilization management. When determining whether emergency care is reimbursable, HMOs must consider:

- an enrollee's belief that immediate medical care was necessary;
- the time and day of the week;
- presenting symptoms; and
- enrollees efforts to follow HMO procedures for emergency care.

Quality assurance measures. Minnesota has very detailed regulation for the components of the HMO quality assurance plan. Every HMO must submit a quality assurance work plan that's implemented annually. Among the components reviewed in the quality assurance plan are referrals, appointment scheduling, waiting periods, second opinions, prior authorization, provider reimbursement arrangements, enrollee complaints, and patient satisfaction. At least once every three years the commissioner must examine, inspect or otherwise evaluate the quality, appropriateness, and timeliness of HMO services. The results of the examinations are considered public information.

Grievance/appeal provisions. Every HMO must establish system for receiving and resolving complaints. Minnesota HMOs must have a three-step grievance process. Step one is an informal resolution of a written complaint with written notice within 30 days. Step two affords complainants a hearing or written reconsideration. If complainant opts for a hearing then a decision must be made within 45 days. If a written reconsideration is chosen then the HMO has 30 days to notify complainant of disposition. The person presiding at the hearing or investigating the reconsideration must not have been involved in the initial denial. All disputes not resolved at hearing or written

reconsideration may be appealed to level three - impartial arbitration. However, this would not include malpractice cases. A complainant may, at any time, file a complaint with the commissioner who can choose to independently review the matter or refer it back to the HMO for further review. If a complaint involves denial or inadequacy of services, the HMO must provide a written statement of reasons within a reasonable time.

Denials for services that are experimental, not medically necessary, or not generally accepted by the medical profession must be afforded expedited review. An expedited review decision must be made within one working day of its receipt and the commissioner must be notified. HMOs must keep a single ongoing log of complaints. Record of all complaints must be maintained for five years. Enrollees must receive annual notice of the complaint process.

Data collection/reporting requirements. The commissioner must annually receive a summary report on complaints, enrollment and disenrollment, physician turnover, and utilization data. Specifically, the data must contain information on hospital discharges, hospital bed days, outpatient visits, lab tests, x-rays, mental health, and chemical dependency services. In addition, statistics must be reported on disease specific and age specific mortality rates. The complaint information must include the number of complaints received, the nature of the complaints, the number of enrollees who registered more than one complaint, and the number of complaints resolved to the complainants' satisfaction. Financial arrangements must be disclosed.

Enrollee representation. As mentioned earlier, HMOs must have enrollee representation on board. The regulations list alternative mechanisms for enrollees to participate in matters of policy and operation including:

- holding special board meetings to allow enrolles to express their opinions;
- establishing special committees which hold meeting for enrollee participation;
- designating an administrative office within the HMO open to enrollees; or
- creating enrollee councils allowed to meet with the governing board.

Solvency protections. Net worth and deposit requirements vary depending on when an HMO was licensed and the length of time it has been operating. Hold harmless clauses must be given to providers. HMOs may engage insurance or reinsurance agreements. Minnesota HMOs must provide continuity of care in the event of contract termination. All HMOs must adopt a conflict of interest policy.

Sanctions. The commissioner may levy administrative penalties up to $25,000 for each violation. In addition, the commissioner may fine an HMO up to $200 for each day information necessary for audit is not provided. Furthermore, a fine of $500 may be imposed every day an annual report is past due and may lead to suspension or revocation of the HMO's certificate of authority.

Legislative activity. Minnesota recently enacted legislation that would provide mothers and newborns with a 48-hour hospital stay following a vaginal delivery and 96 hours after a C-section.

Texas

Regulating authority. Texas managed care is regulated by two agencies: the Department of Insurance and Department of Health. Applicants for a certificate of authority must submit an organizational chart that clearly identifies relationships. A license is not issued until an established ongoing quality assurance program exists. The application must also include a description of the grievance process.

Before issuing a certificate of authority, the commissioner must determine if the HMO is able to meet its obligations to enrollees by examining any agreements for insuring the payment of the cost of health care services or alternative coverage in the event of discontinuance of the plan. Prior to issuing a license the commissioner must be certain that any deposit of cash or securities acts as a guarantee that the obligations will be duly performed. The deposit requirements vary depending on the HMO size and other characteristics.

Advertising prohibitions. Texas prohibits untrue, misleading, and deceptive marketing. The law defines these terms. All marketing forms must be approved by Insurance commissioner prior to use and there are regulatory standards governing their quality of paper and print type. All marketing materials must be kept on file by the HMO and are subject to review by the commissioner.

Market conduct. Enrollees are allowed a 10 day cancellation period after signing up with a plan and are entitled to a premium refund.

Physician accessibility. HMOs must attempt to ensure there are adequate personnel and facilities to provide accessibility and continuity of care. All members must live within the service area and not be forced to travel more than 50 miles to primary physician and acute hospital care and no more than 100 miles for single service providers, referral physicians, and a specialty hospital.

Quality assurance measures. After issuing a certificate of authority, the health commissioner will conduct on-site quality-of-care surveys. A quality assurance program must have a credentialing process, a peer review component, an evaluation of complaint handling, accessibility of services, and an examination of utilization data including referral trends, ambulatory treatment patterns, and hospitalization.

The Department of Health must every three years examine the quality, availability, and accessibility of health care services provided by an HMO. In addition, HMOs must be financially examined once every three years by the insurance department. These examinations are confidential unless it is in the public interest to be released.

Grievance/appeal provisions. Enrollees must receive notice of the complaint process including notice of time limits and appeal procedures. The state may conduct an unannounced investigation of any complaint that represents a threat to the health and safety of members. The HMO

must maintain a log of all written complaints and responses which must be kept for at least three years. Each complaint must be classified by type, detail disposition, and be made available to the state upon request.

Data collection/reporting requirements. The HMO must file annual reports containing enrollment/ disenrollment data and an updated list of physicians and other providers. Applicants must submit an organizational chart that clearly identifies relationships.

Solvency protections. Texas has established an HMO Solvency Surveillance committee to assist and advise the commissioner in the detection and prevention of insolvency problems.

Legislative activity. In January, the insurance department adopted the following rules:

- insurers must disclose information on benefits;
- retaliation against patients and employers who complain about their plan is prohibited;
- managed care plans must provide written reasons when providers are removed from the plan;
- health plans must establish policies to care for patients if their providers leave the network;
- financial incentives that could result in providers withholding necessary care are prohibited; and
- insurers must report data on quality of care, cost, and access so the insurance department can develop performance reports.

Maryland

Regulating authority. The Department of Insurance and the Department of Health and Mental Hygiene share regulatory authority over health care plans. Each application for a certificate of authority must describe the enrollment process, advertising methods, internal grievance process, and the number of physicians and providers by type and specialty. The applicant must also describe its proposed methods to offer its members and public representatives an opportunity to participate in matters of policy and operation.

HMOs must offer the minimum benefits required to be federally qualified HMO. They may not cancel or refuse to renew a member because of age, sex, race, or health status, or terminate an enrollee without providing 30 days advance notice.

HMOs must provide an option for enrollees who lose coverage under a group contract to convert to individual HMO coverage. This may be waived for HMOs which only enroll through group contracts if the HMO has contracted with another health service plan or HMO in same area

to offer insurance at the same premium with no underwriting.

If employers, associations, or other private groups offer health benefit plan coverage to employees or individuals only through an HMO, the HMO must offer, or contract with another carrier to offer, a point-of-service option as an additional benefit for an employee or individual to accept or reject. Employees and individuals choosing a point-of-service plan may be required to pay additional premiums and cost sharing.

Advertising prohibitions. Maryland law prohibits misrepresentation in advertising for health care plans. Every enrollment card and application must state in bold print "If you have any question concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card." The regulations specify the type size for the contract form. All proposed rates, contract, policy, rider, endorsement, or application forms must be approved by insurance commissioner prior to use.

Physician accessibility. Maryland law requires HMOs establish a system whereby services are provided in a timely manner and provider staff patterns be designed to meet enrollee needs. An HMO must provide enrollees a list (updated annually) of the providers in its provider panel including information on which providers are no longer accepting new patients or have been terminated.

Provider protections. Maryland has adopted provider protections. The HMO may not deny an application for participation or terminate participation on its provider panel on the basis of : gender, race, age, religion, national origin, or disability; the type or number of appeals filed by the provider; or the type or number of complaints or grievances the provider filed or requested for review. However, an HMO may reject an application or terminate a provider if the panel has a sufficient number of similarly qualified providers.

Enrollees must be notified of the termination of a primary care physician from the provider panel. The HMO must give the enrollee, on request, the opportunity to continue services from terminated provider for 90 days from the date of notice unless the termination was for reasons such as fraud, patient abuse, incompetency, or loss of licensure.

HMO providers are also afforded right to file a grievance involving the termination from a provider panel. A provider may not be terminated or penalized for advocating the interest of a patient through the carrier's internal review system or by filing an appeal.

Physician credentialing. Each HMO shall collect, review, and verify information concerning a physician's training, certification, hospital privileges, physical and mental status, evidence of any adverse action imposed by any hospital or board, verification of status through the federal National Practitioner Data Bank, and past malpractice claims history.

HMOs must establish a formal written process for the reevaluation of appointment, employment, or selection of a physician every two years. The reevaluation must include an update

of the initial review criteria, an assessment of the performance pattern based on complaints filed through the grievance system, malpractice claims, utilization, quality and risk data, and physician practice patterns.

Quality assurance measures. Every HMO's quality assurance program must ensure 24 hour access to a physician and encourage appropriate history and baseline examinations for each member within a reasonable time of enrollment. A quality assurance review must be conducted periodically. This review may be conducted by a panel of qualified physicians and other health professionals, independent of the HMO, by the health department, or by a peer review organization. The department decides who does the examination. The review must evaluate the professional standards and practices of the HMO in every area of services provided, the grievance process, and a statistically representative sample of member records. In addition, the insurance department must examine the HMO financial operations at least once every three years.

Within a two-year period, each HMO must survey a sample of at least five percent of enrollees who have received services to ascertain their view of the HMO's quality. Survey results must be available to the department for review.

Grievance/appeal provisions. Each HMO must include in its contract a statement that a member or subscriber may complain to the state regarding the operations of the HMO. It must also include an address and telephone number of the department. All grievances must be put in writing and receive a timely written response. At the enrollee's request, the HMO must assist the enrollee in drafting the grievance. The HMO must maintain a written record of each complaint.

If the state investigates prior to exhaustion of the HMO internal process then the state must document its reasons for doing so. Upon receiving the complaint, the state must:

- acknowledge receipt of complaint promptly by telephone or mail;
- notify the HMO of the receipt of the complaint; and
- determine whether the complainant has tried to resolve the complaint through the internal HMO system.

Data collection/reporting requirements. An annual report must contain the number of grievances, number of persons disenrolled by action of the HMO, and summary of reasons for that disenrollment. The HMO must submit statistics on age, sex, and other demographic information as well as a description of community health resources. It must also identify major health problems in the enrolled population and any special enrollee groups that have unique health problems such as the elderly, poor, and mentally ill.

Solvency protections. Each HMO must maintain an initial surplus over liabilities of $1.5 million and maintain a surplus of the greater of $750 thousand or 5% of its subscriber charges up to $3 million. Each HMO must deposit in trust with state treasurer $100,000 for the protection of the HMO members or creditors. Unless granted an exemption, the HMO must purchase reinsurance in

case of catastrophic or unusual losses in excess of their projections. All agreements between the HMO and provider must have a hold-harmless clause prohibiting billing or collecting from enrollees except for allowable co-payments or supplement charges. The clause survives the termination of the provider contract.

In the event of insolvency, each HMO must provide for the continuation of benefits to members for the duration of the contract period for which benefits have been paid and for members who are admitted to an inpatient health care facility on the date of insolvency until discharge or 365 days.

New York

Regulating authority. Managed care in New York is regulated by two agencies: the Department of Insurance and the Department of Health. A license may not be granted until the regulatory agencies are satisfied the applicant has an acceptable quality assurance program and mechanisms are in place to resolve enrollee complaints and grievances.

Within one year after licensure, no less than 20% of the members of the governing body shall be enrollees of the HMO. No less than one third of the members of the governing authority of an HMO shall be composed of residents of the state.

Advertising prohibitions. All information distributed by the HMO must be accurate, factual, and not misleading in any way. HMOs may, prior to obtaining a license, contact potential enrollees to discuss the health care services it would offer. All brokers selling HMO products must be licensed by the Insurance Superintendent who reviews rate filing, fees, and commissions paid.

Quality assurance measures. The quality assurance program must contain a peer review committee, supervision by a medical director, and regularly scheduled and recorded quality assurance meetings. The program must also include methods for identification and selection of clinical and administrative problems as well as the development of timely and appropriate recommendations.

The quality and adequacy of services must be examined once every three years by the Commissioner of Health. This quality examination must include: the number and characteristics of enrollees; utilization of services; complaints and grievances; enrollee participation in policy decisions; and agreements and contracts with providers. Furthermore, the HMO's financial affairs must be examined once every three years by the Insurance Superintendent.

Grievance/appeal provisions. HMOs must respond in writing to enrollee grievances within 15 days. The notice must state whether the resolution of the grievance is complete or in the process with an actual resolution and explanation to follow in a timely manner. HMOs are required to document the receipt and disposition of each grievance or complaint and shall retain these records for at least three years.

Data collection/reporting requirements. Each HMO is required to file quarterly reports to the health commissioner and the insurance superintendent showing the percentage utilization for the preceding quarter of non-participating provider services. Every HMO must file an annual financial statement including analysis of ambulatory care visits, inpatient days, average length of hospital stay, and emergency room visits. The financial statement must also contain information on the enrolled population identified by age groups, sex, and type of enrollee contracts. This information may be printed in summary form for public.

Solvency protections. Each HMO shall establish an initial deposit for the protection of the enrollees equal to the greater of 5 percent of the estimated expenditures for health care services for the year or $100,000. A license will not be issued unless the state is satisfied the applicant is financially responsible. This may require the applicant to obtain insurance for the cost of providing comprehensive health care services.

Legislative activity. As of January 1, 1996, New York law requires HMOs to offer point-of-service plan option to all individual enrollees and demonstrate a willingness to enroll Medicaid and Medicare beneficiaries. Recent proposals before the New York legislature include:

- banning "gag" clauses in physician contracts;
- prohibiting health plans from firing physicians without just cause;
- requiring health plans to release detailed information about their policies including what drugs they pay for, the guidelines they use to reject claims, and their criteria for choosing physicians;
- establishing protocols addressing medical record confidentiality;
- allowing patients with chronic illnesses to choose specialists as primary care physicians; and
- requiring health plans to pay for emergency room visits when a "prudent lay person" could expect that he has a serious health condition.

New Jersey

New Jersey has recently proposed a complete overhaul of their HMO regulatory system. The following is a synopsis of the proposed regulations currently in the public review and comment phase.

Regulating authority. The Department of Insurance and Department of Health share the regulatory authority of managed care. To become operational, an HMO applicant must obtain a certificate of authority from the health commissioner and pay a $100 application fee. The applicant must submit copies of the organizational structure, bylaws, group and individual forms, and sample provider contracts including any financial incentives. The application must include: biographical information of HMO officers, proposed marketing strategy, listing of providers by geographical service area, enrollment projections for the first three years of operation, and method of ensuring enrollee participation.

The HMO must disclose the criteria used for determining availability and adequacy of provider networks and ensuring access to specialities. It must also describe its continuous quality improvement and utilization management programs as well as its efforts to ensure that members with language and cultural differences obtain services. In addition, the HMO must provide attestations that it is in regulatory compliance in all other states in which it operates.

Advertising prohibitions. New Jersey has prohibition against false and misleading advertising. Every HMO that has an arrangement with providers whereby some portion of the total possible compensation is contingent upon the provider meeting certain unitization criteria shall include in all its marketing and advertising materials the following disclosure statement: "Compensation of a participating health care provider is based, in part, upon the health care provider meeting health care practice standards established by agreement between the health care provider and the HMO."

Data collection/reporting requirements. Annually and quarterly reports must be submitted to the departments of insurance and health containing membership, utilization, financial, and descriptive plan information. In addition, annual summary of complaint information must be provided. The summary must include: the total number of complaints and utilization management appeals categorized by cause and disposition; the average length of time for resolution; and the number, amount, and disposition of malpractice claims against the HMO.

Physician accessibility. Each HMO must maintain an adequate network of providers. In its application for licensure, HMOs must demonstrate that there are 2 primary care physicians within 10 miles or 30 minutes driving time for 90 percent of the enrolled population. Access to specialists must be within 45 miles or 1 hour driving time.

Provider protections. HMOs must establish a policy governing the termination of providers. Providers' contracts must specify time and manner of termination notice. Written notification to each member within 30 days prior to termination or withdrawal. Enrollees must be provided up to 120 days of continued coverage with a terminated provider if treatment is medically necessary.

Utilization management. Each HMO must submit a description of its utilization management program to the departments. This must include: the clinical review criteria and protocols used in decision making; methods to ensure consistent application of review criteria and uniform decisions; mechanisms to detect under and over utilization; and appeal procedure for providers and members. A registered professional nurse or physician must be immediately available by phone 7 days a week, 24 hours a day to render utilization decisions. All determinations to deny or limit an admission, service, procedure or extension of stay must be determined by a physician. The HMO must establish written policies and procedures governing the provision of emergency and urgent care.

Quality assurance measures. A continuous quality improvement program must be implemented. The program must evaluate the availability, accessibility, and quality of care. It must

conduct individual case reviews as well as pattern trends. It must monitor member satisfaction and have a credentialing system for providers. Each HMO must undergo an external quality audit every three years by an independent quality review organization approved by the departments. In addition, the Department of Health and the Department of Insurance may conduct examinations of the quality of health care and other services provided by the HMO to ensure regulatory compliance.

Grievance/appeal provisions. The HMO must establish a grievance process to respond to complaints within 30 days. Complaint records must be maintained for at least three years. Each member and provider must receive written notice that they may contact the department's of health and insurance if dissatisfied with the resolution reached through the HMO's internal complaint system.

Solvency protections. In order to obtain certificate of authority, HMOs must have a minimum net worth of $1,500,000 and deposit $300,000 with the insurance commissioner. In order to maintain its certificate, HMOs must maintain a minimum net worth of $1,000,000 or two percent of the annual premium revenues reported on its most recent annual financial statement. Each HMO must establish an insolvency plan assuring continuation of services and benefits to members in the event the HMO becomes or is determined to be insolvent.

APPENDIX E
Internal HMO Grievance Process

Appendix E. Comparison of HMO Grievance Process

Name	Healthsource	Connecticare	PHS	Suburban	Aetna	Wellcare
Time for submission	180 days	1 year	6 months	n/a	90 days	90 days
Level I						
Format	written/ phone	written	written/phone	written/phone	written/phone	written *
Reviewed by	member service rep.	n/a	member service rep.	member service rep.	member service rep.	member service rep.
Response time	n/a	n/a	n/a	n/a	10 days	7 days
Notification	n/a	n/a	n/a	n/a	written	written (w/ reasons)
Level II						
Format	written	written	written/phone	written (w/in 15 days)	written (w/in 30 days)	written (w/in 7 days)
Reviewed by	Review Comm.	Mngnt. Comm.	Reconsider. Comm.	Ezec. Dir. & staff	Exec. Dir & staff	Exec. Dir & staff
Response time	30 days	n/a	n/a	31 days	n/a	14 days
Notification	written	written	n/a	written	written	n/a
Hearing	n/a	n/a	automatic	at enrollee request	n/a	at enrollee request
Level III						
Format	written	written (w/in 10 days)	written/phone	n/a	written (w/in 30 days)*	written (w/in 7 days)
Reviewed by	Grieve. Comm.	Bd. of Dir.	Senior Mngmnt.	n/a	Appeal Review Comm.	Bd. of Dir. (Subcomm.)
Response time	30 day	n/a	n/a	n/a	n/a	14 days
Notification	n/a	n/a	n/a	n/a	n/a	n/a
Hearing	at agency discret.	n/a	at enrollee request	n/a	n/a	at enrollee request
Appeal to State	yes	yes	no	yes	no	yes

* Specifies what to include
n/a not mentioned

Appendix E. Comparison of HMO Grievance Process (continued).

Name	BlueCross/BlueShield	Cigna	Kaiser	Oxford	USHealthcare	MDHealth
Time for submission	n/a	n/a	n/a	n/a	n/a	n/a
Level I						
Format	written/phone	written/phone	written/phone	written/phone	written/phone	phone
Reviewed by	member service rep	member service rep	member service rep	member service rep	member service rep	member service rep
Response time	n/a	n/a	30 days	15 days	5 days	48 hours
Notification	n/a	n/a	n/a	written	n/a	n/a
Level II						
Format	written (w/in 60 days)	written	written (w/in 30 days)	written/phone	written/phone	written (w/in 30 days)
Reviewed by	Appeal Comm.	"appropriate official"	n/a	Grieve. Comm.	Grieve. Comm.	Grievce. Comm.
Response time	n/a	n/a	n/a	15 days	30 days	30 days
Notification	n/a	n/a	written	written	written	n/a
Hearing	n/a	n/a	n/a	agency discret.	agency discret & member convience	n/a
Level III						
Format	written (w/in 60 days)	written	n/a	written	written	written (w/in 30 days)
Reviewed by	Grieve. Comm.	Grieve. Comm.	n/a	Bd. of Dir.	President	Appeal Comm.
Response time	60 days	n/a	n/a	15 days	30 days	30 days
Notification	written (w/ reason)	written	n/a	n/a	n/a	n/a
Hearing	at enrollee request	agency discret. (written testimony only)	n/a	n/a	n/a	at enrollee request
Appeal to State	yes	yes	no	yes	yes	yes

* Specifies what to include
n/a not mentioned

APPENDIX F
Health Care Complaints Received by the Department of Insurance

APPENDIX F. Health Care Complaints Received by the Department of Insurance

Table F-1 provides the number of complaints and inquiries relating to health plans since 1990. As demonstrated by the table, the total number of health care complaints has decreased in the last five years. This may be due to a variety of reasons including: consumers becoming more knowledgeable about managed care; health plans doing a better job of resolving complaints internally; or the insurance department becoming more efficient at resolving issues over the phone without actually logging the complaint. Nevertheless, it is interesting to note that while the number of complaints against HMOs and health insurance carriers have gone down, the number of complaints against utilization review companies, though still relatively low, has increased.

Table F-1. DOI Complaints Relating to Health Plans 1990-1996

Against	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*	*1996**
Ins. Co.	2,058	2,057	2,186	1,803	1,545	1,243	625
HMO	328	462	419	337	238	299	276
PPO	--	--	16	19	13	6	10
Utiliz.	--	--	9	30	16	30	46
Total	2,386	2,519	2,630	2,189	1,812	1,578	957

*As of June 18, 1996
Source of data: LPR&IC 1996

Complaint analysis: origin and reason. The origin of complaints is presented in Table F-2. As the table shows, the insured is by far the most frequent complainant while service providers consistently come in second as the most common complaint origin. Applicants, attorneys, and agents are also regular sources of complaints. Table F-3 lists the top five reasons for registering a complaint. Denials, delays, and other claim administration problems continually rank in the top five reasons. Other issues among the top five reasons involve medical necessity, premiums and ratings, and usual and customary fees. General information inquiries are also common.

Complaint analysis: outcomes. There are several ways in which the examiner can resolve a complaint. When the examiner concludes the licensee is correct, the complaint is categorized as "unjustified". Conversely, when an examiner makes a determination against the licensee the complaint is considered "justified". In situations where the licensee has exhibited reasonable facts and documents which support their handling and position suggesting that they *may not* be responsible the examiner may classify the complaint as "questionable".

Responses to general informational inquiries are typically coded as "furnished information". Similarly, an examiner may label the complaint file with "satisfactory explanation" when a complaint

determination is not needed but rather an explanation to the complainant is necessary. If the complainant withdraws the complaint, or the complaint is filed for record purposes only or is outside the department's jurisdiction, the file is coded as "no action necessary". A "voluntary reconsideration" is used when the licensees have statutory, regulatory, or contractual support for their position but nevertheless agree to reconsider their position in favor of the complainants. Committee reviewed the justification codes of the selected complaints. The results are shown in Table F-4.As the table shows, complaints against HMOs and insurance carriers are more likely to be found unjustified than justified or questionable. Typically, there is a higher percentage of a satisfactory explanation or furnishing of information. On occasion, a health plan may voluntarily reconsider its position or the department finds further action is not needed.

Annually, the insurance department issues a report that lists the complaints by individual company and then ranks the companies by the number of complaints received by the amount of premiums written. Table F-5 lists the department's 1995 numerical ranking of health maintenance organizations. The HMO with the **lowest** complaint ratio is ranked number one.

Table F-2. Department of Insurance Complaints by Top Five Types of Complainant: 1993-1996

	1993	*1994*	*1995*	*1996 (as of 6/96)*
HMO	*N= 337* Insured 233 (69%) Provider 66 (20%) Applicant 12 (4%) Attorney 9 (3%) 3rd Party 7 (2%) Other 10 (3%)	*N=238* Insured 166 (70%) Provider 44 (18%) Employer 6 (3%) Agent 6 (3%) Attorney 5 (2%) Other 11 (5%)	*N=299* Insured 197 (66%) Provider 60 (20%) Attorney 16 (5%) Applicant 8 (3%) Legislator 5 (2%) Other 13 (4%)	*N=276* Insured 199 (72%) Provider 43 (16%) Attorney 10 (4%) Legislator 5 (2%) Employer 5 (2%) Other 14 (5%)
Insur. Co.	*N=1803* Insured 1241 (69%) Provider 284 (16%) Applicant 55 (3%) Attorney 54 (3%) Agent 31 (2%) Other 138 (8%)	*N=1545* Insured 1060 (69%) Provider 235 (15%) Applicant 103 (7%) Agent 49 (3%) Attorney 45 (3%) Other 53 (3%)	*N=1243* Insured 807 (65%) Provider 201 (16%) Attorney 49 (4%) Applicant 44 (3%) Agent 43 (3%) Other 99 (8%)	*N=625* Insured 413 (66%) Provider 88 (14%) Applicant 49 (8%) Attorney 22 (4%) Agent 13 (2%) Other 40 (6%)
PPOs	*N=19* Insured 9 (47%) Provider 4 (21%) Attorney 3 (16%) Other 3 (16%)	*N=13* Insured 8 (62%) Provider 3 (23%) Other 2 (15%)	*N=6* Provider 3 (50%) Insured 2 (33%) Agent 1 (17%)	*N=10* Insured 6 (60%) Provider 4 (40%)
Utiliz. Co.	*N=30* Insured 16 (53%) Provider 11 (37%) Other 3 (10%)	*N=16* Provider 10 (63%) Insured 5 (31%) Applicant 1 (6%)	*N=30* Insured 18 (60%) Provider 10 (33%) Other 2 (7%)	*N=46* Insured 32 (70%) Provider 9 (20%) Attorney 2 (4%) Agent 2 (4%) Applicant 1 (2%)

Source of data: LPR&IC 1996

Table F-3. Department of Insurance Complaints by the Top Five Reasons 1993-1996				
	1993	*1994*	*1995*	*1996 (as of 6/96)*
HMO	N= 337 Deny claim =110 (33%) Claim delay=41 (12%) Claim Proc=37 (11%) Comp hand=28 (8%) Info inquiry=17 (5%)	N=238 Deny claim=78 (33%) Claim Pro=32 (13%) Claim delay=20 (8%) Not Med Nec=17 (7%) Comp hand=15 (6%)	N=299 Deny claim=78 (26%) Claim Pro=40 (13%) Claim delay=27(9%) Prem&Rating=25 (8%) Not Med Nec=21(7%)	N=276 Deny claim=52 (19%) Claim delay=28(10%) Prem&Rating=22 (8%) Claim Pro=22 (8%) Not Med Nec=20 (7%)
Insur. Co.	N=1803 Deny claim=464 (26%) Claim delay=209 (12%) U&C Fee=136 (7%) Claim Pro=125 (7%) Info inquiry=112 (6%)	N=1545 Deny claim=254 (16%) Claim delay=177 (11%) Info inquiry=148 (10%) U&C Fee=131 (8%) Claim Pro=110 (7%)	N=1243 Deny claim=224 (18%) Claim delay=119 (9%) Info inquiry=118 (9%) Prem&Rating=106 (8%) U&C Fee=97 (8%)	N=625 Deny claim=97 (15%) Info inquiry=69 (11%) Claim delay=65 (10%) Prem&Rating=53 (8%) Claims Other=40 (6%)
PPOs	N=19 Deny claim=5 (26%) Claim delay=4 (21%) Claims Other=4 (21%)	N=13 Claims Other=5 (38%) Claim Pro=3 (23%)	N=6 Info inquiry=2	N=10 Info inquiry=2
Utiliz. Co.	N=30 Comp hand=7 (23%) Deny claim=4 (13%) Claim Pro=3 (10%) Claim delay=3 (10%) Claims Other=3 (10%)	N=16 Claim Pro=4 (25%) Claims Other=2 (12%) Claim delay=2 (12%) Not Med Nec=2 (12%)	N=30 Case Mangmnt=9 (30%) Claim delay=8 (26%) Not Med Nec=4 (13%) Deny claim=4 (13%)	N=46 Claim delay=6 (13%) Deny Claim=6 (13%) Claim Other=4 (8%) UR Proc=3 (6%) Cov Denied=3 (6%)

Source of data: LPR&IC 1996

Table F-4. Department of Insurance Complaints by Type of Justification 1993-1996				
	1993	*1994*	*1995*	*1996**
HMO	N= 337	N=238	N=299	N=276
Justified	31 (9%)	19 (8%)	35 (12%)	18 (7%)
Unjustified	115(34%)	67 (28%)	53 (18%)	24 (9%)
Questionable	13 (4%)	8 (3%)	8 (3%)	1 (<1%)
Furnish Information	36 (11%)	42 (18%)	38 (13%)	45 (16%)
Satisfactory Explanation	84 (25%)	55 (23%)	83 (28%)	30(11%)
No Action Necessary	14 (4%)	15 (6%)	16 (5%)	12 (4%)
Voluntary Reconsideration	36 (11%)	24 (10%)	18 (6%)	--
Cross Reference	8 (2%)	3 (1%)	6 (2%)	--
Insur. Co.	N=1803	N=1545	N=1243	N=625
Justified	105 (6%)	81 (5%)	71 (6%)	18 (3%)
Unjustified	494 (27%)	348(23%)	272 (22%)	24 (4%)
Questionable	60 (3%)	40(3%)	32 (3%)	1 (<1%)
Furnish Information	391(22%)	363(23%)	266 (21%)	45 (7%)
Satisfactory Explanation	495 (27%)	423(27%)	346 (28%)	30 (5%)
No Action Necessary	110 (6%)	128(8%)	133 (11%)	12 (2%)
Voluntary Reconsideration	109 (6%)	118 (8%)	87 (7%)	--
Cross Reference	18 (<1%)	14 (<1%)	21 (2%)	--
PPOs	N=19	N=13	N=6	N=10
Justified	--	--	--	--
Unjustified	5 (26%)	2 (15%)	1 (17%)	--
Questionable	2 (11%)	--	--	--
Furnish Information	6 (32%)	5 (38%)	4 (67%)	4 (40%)
Satisfactory Explanation	5 (26%)	3 (23%)	1 (17%)	1(10%)
No Action Necessary	1 (5%)	1 (8%)	--	--
Voluntary Reconsideration	--	1 (8%)	--	1 (10%)
Cross Reference	--	--	--	--
Utiliz. Co.	N=30	N=16	N=30	N=46
Justified	6 (20%)	1 (6%)	2 (7%)	7 (15%)
Unjustified	6 (20%)	2 (12%)	1(3%)	1 (2%)
Questionable	--	--	2 (7%)	--
Furnish Information	5 (17%)	5 (31%)	8 (27%)	4 (9%)
Satisfactory Explanation	10 (33%)	4 (25%)	14 (47%)	6 (13%)
No Action Necessary	3 (10%)	4 (25%)	1(3%)	--
Voluntary Reconsideration	--	--	--	2 (4%)
Cross Reference	--	--	--	--

* As of 6/18/96 - Several are cases still open with no justification code.
Cross reference: multiple files of same complaint.
Source of data: LPR&IC 1996

Table F-5. DOI Numerical Ranking of Health Maintenance Organizations (1995).			
HMO	*Direct Premium*	*Justifiable/Questionable*	*Ratio*
Prudential	8,121,645	0/0	.000
Suburban	6,699,196	0/0	.000
Physician Health Services	277,792,663	1/0	.003
Community Health Care Plan	83,468,322	0/1	.011
Kaiser	80,654,401	1/0	.012
Blue Cross Blue Shield	339,642,618	5/0	.014
Connecticare	205,168,499	4/0	.019
Aetna	149,285,548	2/2	.026
MDHealth	176,660,471	4/1	.028
Cigna	23,159,097	1/0	.043
Oxford	16,216,512	0/1	.061
USHealthcare	75,193,389	2/3	.066

HMO with *lowest* complaint ratio is ranked number one.
HMOs not ranked: **New License**: Healthsource, Wellcare, Yale Preferred. **Merged into Blue Cross:** Constitution Healthcare, Enterprise Health Plan

Source of data: Insurance Department

APPENDIX G
Managed Care Glossary

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Managed Care Glossary

adverse selection - a term used to describe a situation in which a carrier enrolls a poorer risk than the average risk of the group.

board certified - a term used to describe a physician who has passed an examination given by a medical speciality board and who has been certified as a specialist in that medical area.

board eligible - a term used to describe a physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training , and practiced for a specified amount of time.

capitation - a method of paying for medical services on a per-person rather than a per-procedure basis. Under capitation, an HMO pays a participating doctor a fixed amount per month for every HMO member he or she takes care of, regardless of how much or how little care the member receives.

carrier - an entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

concurrent review - an assessment of hospital admissions, conducted by trained managed care staff via telephone or on-site visits during a covered person's hospital stay, to ensure appropriate care, treatment, length of stay, and discharge planning.

credentialing - a process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

drug formulary - a listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to a covered person. This list is subject to periodic review and modification by the health plan.

Employee Retirement Income Security Act of 1974 (ERISA) - federal law that mandates reporting and disclosure requirements for group life and health plans.

enrollee - an individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf to receive the health services provided under the contract.

evidence of coverage - a description of the benefits included in a carrier's plan. This is required by state laws and represents the coverage provided under the contract issued to the employer. It is provided to the employee.

exclusive provider organization - a term derived from the phase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services, an EPO provides coverage only for contracted providers; hence, the term exclusive. Technically, many HMOs can also be described as EPOs.

federal qualification - a designation made by HCFA after conducting an evaluation process of the HMO's method of doing business,

documents, contracts, and systems. An organization must be federally qualified to be eligible to participate in certain Medicare cost and risk contracts.

fee for service - the traditional method of paying for medical services. A doctor charges a fee for each service provided, and the insurer pays all or part of that fee. Sometimes the patient pays a copayment for each visit to the doctor.

gatekeeper - a situation in which a primary care physician, the "gatekeeper", serves as the patient's initial contact for medical care and referrals.

Health Care Financing Administration (HCFA) - the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid.

health maintenance organization (HMO) - an organization that provides health care in return for preset monthly payments. Most HMOs provide care through a network of doctors, hospitals and other medical professionals that their members must use in order to be covered for that care.

individual practice association (IPA) HMO model - a health care model that contracts with an individual practice association to provide services for a negotiated fee. The individual practice association in turn contracts with physicians who continue their own individual or group practice. The individual practice association may compensate the physician on a per capita, fee schedule, or fee-for-service basis.

inpatient - an individual who has been admitted to hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

managed care organization - an umbrella term for HMOs and all health plans that provide health care in return for pre-set monthly payments and coordinate care through a defined network of primary care physicians and hospitals.

mandated benefits - those benefits which health plans are required by state or federal law to provide to policy holders and eligible dependents.

medical loss ratio - the cost ratio of health benefits used compared to revenue received.

medically necessary - a service or treatment which is appropriate and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.

member - a participant in a health plan who is part of the plan's enrollment.

non-participating provider - a term used to describe a provider who has not contracted with the carrier or health plan to be a participating provider of health care.

participating provider - a provider who has contracted with the health plan to provide medical services to covered persons.

peer review - the evaluation of quality of total health care provided by medical staff with equivalent training.

point-of-service - a type of health plan allowing the covered person to choose to receive a service from a participating or a non-participating provider with different benefit levels associated with the use of participating providers.

pre-existing - any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage under the master group contract.

preferred provider organization (PPO) - a network of doctors and hospitals that provides care at lower cost than through traditional insurance.

primary care physician - a physician, usually an internist, pediatrician, or family physician, devoted to general medical care of patients. Most HMOs require members to choose a primary care physician, who is then expected to provide or authorize all care for that patient.

quality assurance - a formal set of activities to review and affect the quality of services provided and corrective actions to remedy any deficiencies.

reasonable and customary fee - a term used to refer to the commonly charged or prevailing fees for health services within a geographic area.

referral - a formal process that authorizes an HMO member to get care from a specialist or hospital. To assure coverage, an HMO patient generally must get a referral from his or her primary care doctor before seeing a specialist.

referral provider - a provider who renders a service to a patient who has been sent to him/her by a participating provider in the health plan.

reinsurance - insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees.

retrospective review - a method of determining medical necessity and/or appropriate billing practice for services which have already been rendered.

self-funded, self-insurance - a health care program in which employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self administered or the employer may contract with an outside administrator for an administrative-services-only arrangement.

third party administrator - an independent person or corporate entity who administers group benefits, claims, and administration for a self-insured company or group.

utilization management/review - the process of evaluating the necessity, appropriateness, and efficiency of health care services. A review coordinator gathers information about the proposed hospitalization, service, or procedure from the patient and/or provider, then determines whether it meets established guidelines and criteria.